

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06807

6813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

6 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middletown

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Frederick Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
AlbertMiddle
M.Last
Ahalt4. DATE
OF
DEATHMonth
6Day
9Year
1958

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9/15/1874

9. AGE (In years
from birthday)
yrs.

83

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

farm owner, ret.

10b. KIND OF BUSINESS OR INDUSTRY

farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joshua D. Ahalt

14. MOTHER'S MAIDEN NAME

Laura E. Shafer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

J. Guy Ahalt, Middletown, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

162.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Primary Bronchogenic
Carcinoma with metastatic spread 2/1/58INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Coronary Sclerosis & Previous infarcts

19. WAS AUTOPSY PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 7/4 1952, 18, that I last saw the deceased alive on 6/19/58, and that death occurred at L P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Dr. A. Talbott Brice

Jefferson, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

burial

22b. DATE THEREOF

6/11/1958

22c. NAME OF CEMETERY OR CREMATORIUM

Lutheran Cemetery

22d. LOCATION (City, town, or county)

Middletown

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Gladhill Company, Middletown, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE JUN 12 '58

24b. REGISTRAR'S SIGNATURE

A. Brice

CERTIFICATE OF DEATH

1992-00000000

STATE OF COLORADO

DEATH CERTIFICATE
RECEIVED

MAY 10 1992

DEPT. OF PUBLIC SAFETY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6814 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

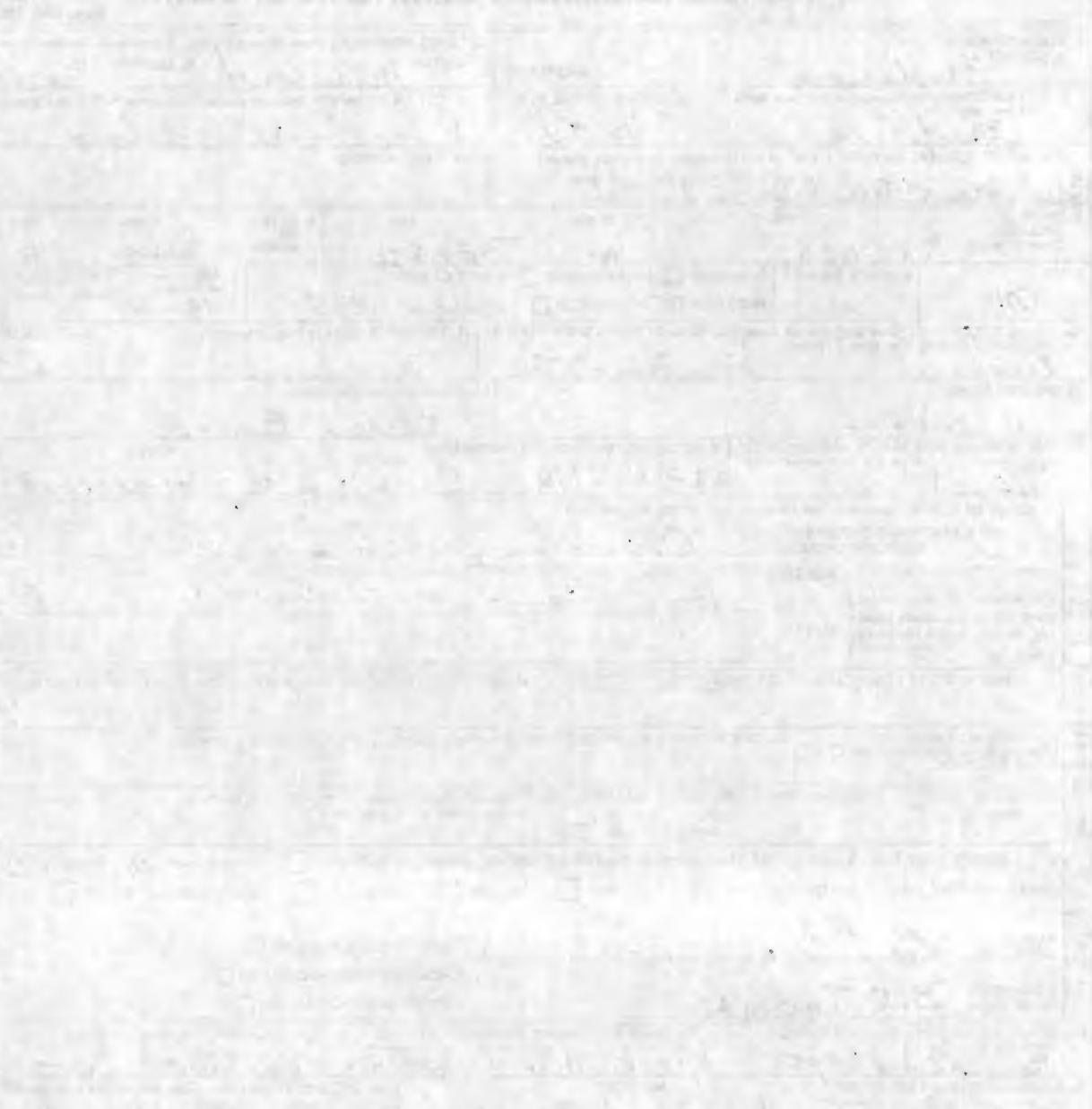
06808

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN lb <u>1/2 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fred. Iron + Steel, 2nd & E. 7th St.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodsboro</u>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND</u>		First <u>W.</u>	Middle <u>BEARD</u>
4. DATE OF DEATH <u>June 6 1958</u>	Month	Day	Year
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Jan. 27 1885</u>
8. AGE (In years last birthday) <u>73</u> yrs.	9. IF UNDER 1 YEAR <u>Months</u>	10. IF UNDER 24 HRS. <u>Days</u>	11. Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fred. Iron + Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Beard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-1970</u>	
		17. INFORMANT <u>Mrs. Alvie Smith, Woodsboro Rd., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>numilia</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Hyper tension arteriosclerosis</u> DUE TO <u>2 yr. f.</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. O. Thomas</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) <u>B. O. THOMAS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/8/58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Rocky Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Woodsboro, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u>		ADDRESS	24a. REC'D BY REGISTRAR <u>JUN 10 '58</u>
		DATE	24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>

ОГЛАШЕНИЕ ПОСЛАНИЯ
ПРАВСКОГО ГОСУДАРСТВЕННОГО СОВЕТА



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06809

6815

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 24 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Linganore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle WILLIAM	Last WESLEY BENNETT	4. DATE OF DEATH Month June	Day 26,	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 25 Oct 1881	9. AGE (In years lost birthday) 76	IF UNDER 1 YEAR yrs. Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Bennett		14. MOTHER'S MAIDEN NAME Anna May Andrews					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Grover C. Tobery		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia						INTERVAL BETWEEN ONSET AND DEATH 1 weeks	
148X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of pharynx						1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick Shopping Center	
21. I certify that I attended the deceased from Oct. , 19 57 , to June 26 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at 6:15P M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Frederick, Maryland	
ACTUAL SIGNATURE <i>Ralph L. Michels</i>	PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D.		M.D.		DATE SIGNED 6/28/58		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-30-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06810

6816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 307 West 2nd. St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chronic Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Paul	Middle 	Last Blackwell, Sr.	4. DATE OF DEATH June 5 1958	Month June	Day 5	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> *HUSBAND DEPARED <input type="checkbox"/>	B. DATE OF BIRTH February 22, 1892	9. AGE (In years from birthday) 66 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Contractor and Builder		10b. KIND OF BUSINESS OR INDUSTRY Homes		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Blackwell		14. MOTHER'S MAIDEN NAME Rachel Draper					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Samuel Fisher-307 W. 2nd. St.-Frederick-		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. carcin of colon						INTERVAL BETWEEN ONSET AND DEATH 6-12 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 58 , to June 5 , 19 58 , that I last saw the deceased alive on June 5 , 19 58 , and that death occurred at 6:57 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Rex R. Martin PHYSICIAN'S NAME (Type) Dr. Rex R. Martin						ADDRESS (Street, city or town, state) 35 East Church St., Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E.Cline & Son		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE JUN 5 1958		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06811

Reg. Dist. No.

6817

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 35 Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12 North Market Street		d. STREET ADDRESS 211 Delaware Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Catherine	Last Boyer
4. DATE OF DEATH	Month June	Day 21	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 26-1906
9. AGE (In years less than birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Luther Malone		14. MOTHER'S MAIDEN NAME Mary Lou Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. Address Mr. Harvey S. Boyer, Brunswick, Maryland	
17. INFORMANT 420.1		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH months	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O.Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/21/1958
22b. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22c. DATE THEREOF 6/24/1958	22d. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mountain View Brunswick, Maryland	22e. LOCATION (City, town, or county) (State) Sharpsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt	24a. REC'D BY REGISTRAR DATE JUN 26 '58	24b. REGISTRAR'S SIGNATURE Alfred Louch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Irregular Permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILDCAT EXCAVATOR & EQUIPMENT CO. INC.

1000 ft

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6843

CERTIFICATE OF DEATH

06812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Middletown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Middletown		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harold	Middle Latimore	Last Brooks	4. DATE OF DEATH	Month June	Day 16	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 13, 1880	9. AGE (in years lost, birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		Address Mrs. Barbara Brooks, Middletown, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO. 220-10-5783		17. INFORMANT C. E. Pruitt		INTERVAL BETWEEN ONSET AND DEATH 2 months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Petersville Cem.		20f. (City or town) (County) (State) Petersville, Md.	
21. I certify that I attended the deceased from 6-12-1958 to 6-16-1958 , that I last saw the deceased alive on 6-16-1958 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE C. E. Pruitt		ADDRESS (Street, city or town, state) Petersville, Md. DATE SIGNED 6-17-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Petersville Cem.		22d. LOCATION (City, town, or county) (State) Petersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 23 58		24b. REGISTRAR'S SIGNATURE Reediech	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6818

CERTIFICATE OF DEATH

Reg. Dist. No. 06813

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 116 West Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FLOSSIE	Middle ELLIOTT	Last CAIN	4. DATE OF DEATH December 29, 1898	Month June	Day 19,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 29, 1898	9. AGE (In years (at birthday) yrs. 59	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Ashley Cain				14. MOTHER'S MAIDEN NAME Rosa May Main			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No—Unknown) No		16. SOCIAL SECURITY NO. 212-38-7517		17. INFORMANT Mrs. William N. Shirey, Frederick, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Abdominal Carcinomatosis	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Carcinoma of appendix		(c)		INTERVAL BETWEEN ONSET AND DEATH 6 7 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jen (County) Jen (State) Md	
21. I certify that I attended the deceased from Jen , 1957, to Jen , 1958, that I last saw the deceased alive on Jen , 1958, and that death occurred at 6:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles H. Conley</i>		ADDRESS (Street, city or town, state) M.D. Professional Building DATE SIGNED 6/20/58					
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.		Frederick, Maryland					
22a. BURIAL CREMATION, REMOVED <input type="checkbox"/> Burial		22b. DATE THEREOF June 21, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
						24b. REGISTRAR'S SIGNATURE <i>Alt. eden</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 & 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06814

6819 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 2 West Second Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mrs Ethel W. Castle	Middle	Last
4. DATE OF DEATH	Month June	Day 27	Year 1958
5. SEX Female	6. COLOR OR RACE Wt	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2-1894
9. AGE (In years (last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Waters		14. MOTHER'S MAIDEN NAME Elizabeth Lerch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None	
17. INFORMANT No		Mr. Harry C. Castle-2 W. 2nd. St.-Frederick-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 4 mo.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Extension from Primary Carcinoma 4 years	
DUE TO (c)		of the Transverse Colon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491 Bruchs - Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 1958, to June 27, 1958, that I last saw the deceased alive on June 27, 1958, and that death occurred at 9 P.M., from the causes and on the date stated above. ADDRESS (Street, city, town, state) ACTUAL SIGNATURE J. A. A. Pearre M.D. Frederick, Md. DATE SIGNED 6/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1-1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. L. & Son		24a. REC'D BY REGISTRAR DATE 30 '58	
ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE DeLaril	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

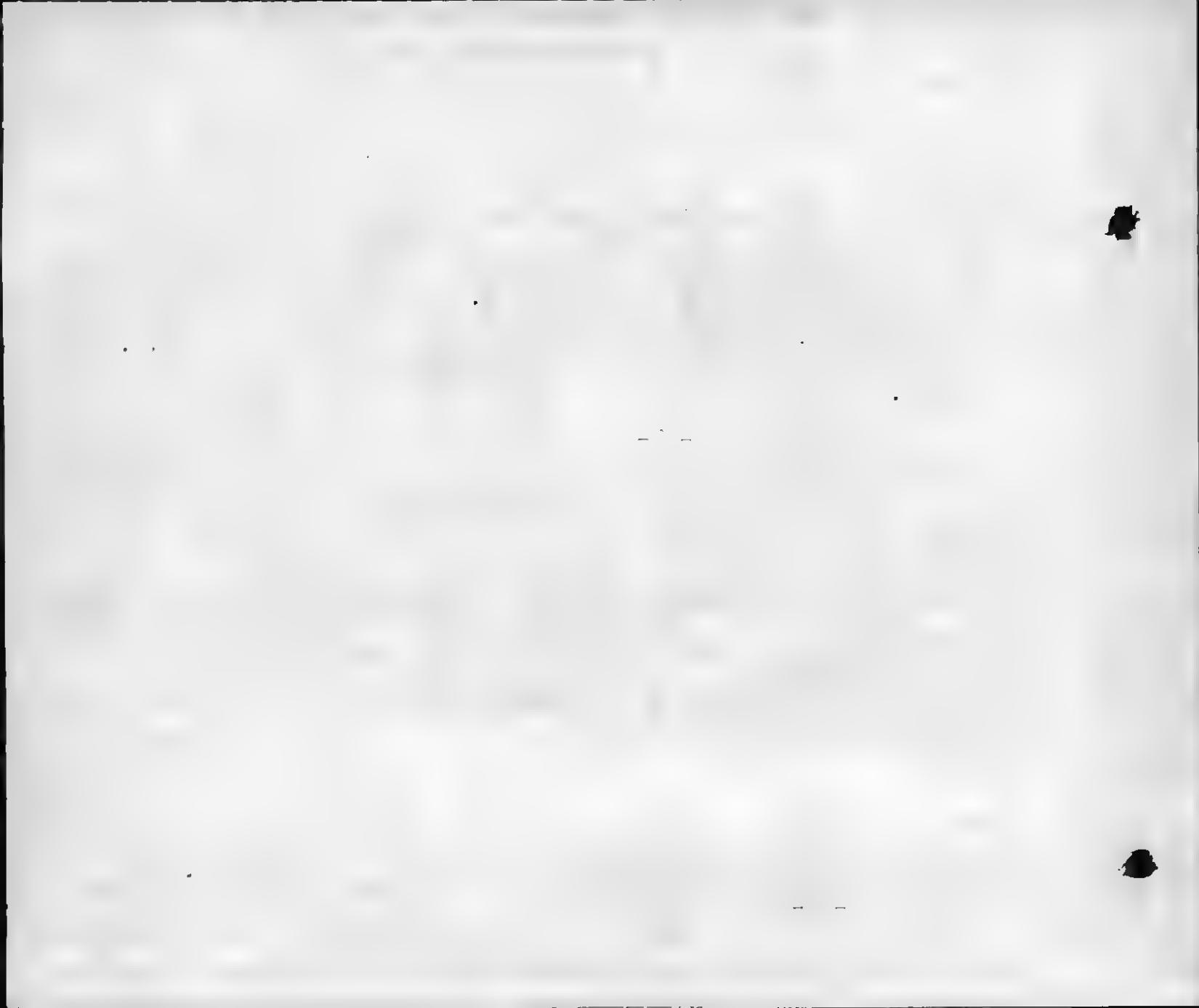
06815

Reg. Dist. No.

6820

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rocky Ridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION, Frederick Memorial Hospt.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARVEY	Middle T.	Last CLEM
4. DATE OF DEATH	Month June	Day 10	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 4, 1905
8. AGE (In years last birthday) 52 yrs		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Contracting	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Clem		14. MOTHER'S MAIDEN NAME Bessie Eckenrode	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-07-2770	
17. INFORMANT		Address Mrs. Harry Sayler Rocky Ridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cardiac decompensation</i>			
DUE TO (c) <i>Rheumatic heart disease</i>			
INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 9</i> , 1958, to <i>June 10</i> , 1958, that I last saw the deceased alive on <i>June 9</i> , 1958, and that death occurred at <i>4:45A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E.A. Dettbarn</i>		ADDRESS (Street, city or town, state) <i>Malvern Hill, Md.</i> DATE SIGNED <i>June 10/58</i>	
PHYSICIAN'S NAME (Type) <i>E.A. DETTBARN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-13-58	22c. NAME OF CEMETERY OR CREMATORIUM Graceham Cemetery	22d. LOCATION (City, town, or county) (State) Graceham, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Rayrend E. Creager		ADDRESS Thurment, Maryland	24a. REC'D BY REGISTRAR DATE JUN 16 '58
			24b. REGISTRAR'S SIGNATURE <i>Asst. Reg.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log #4
 may be
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6844

CERTIFICATE OF DEATH

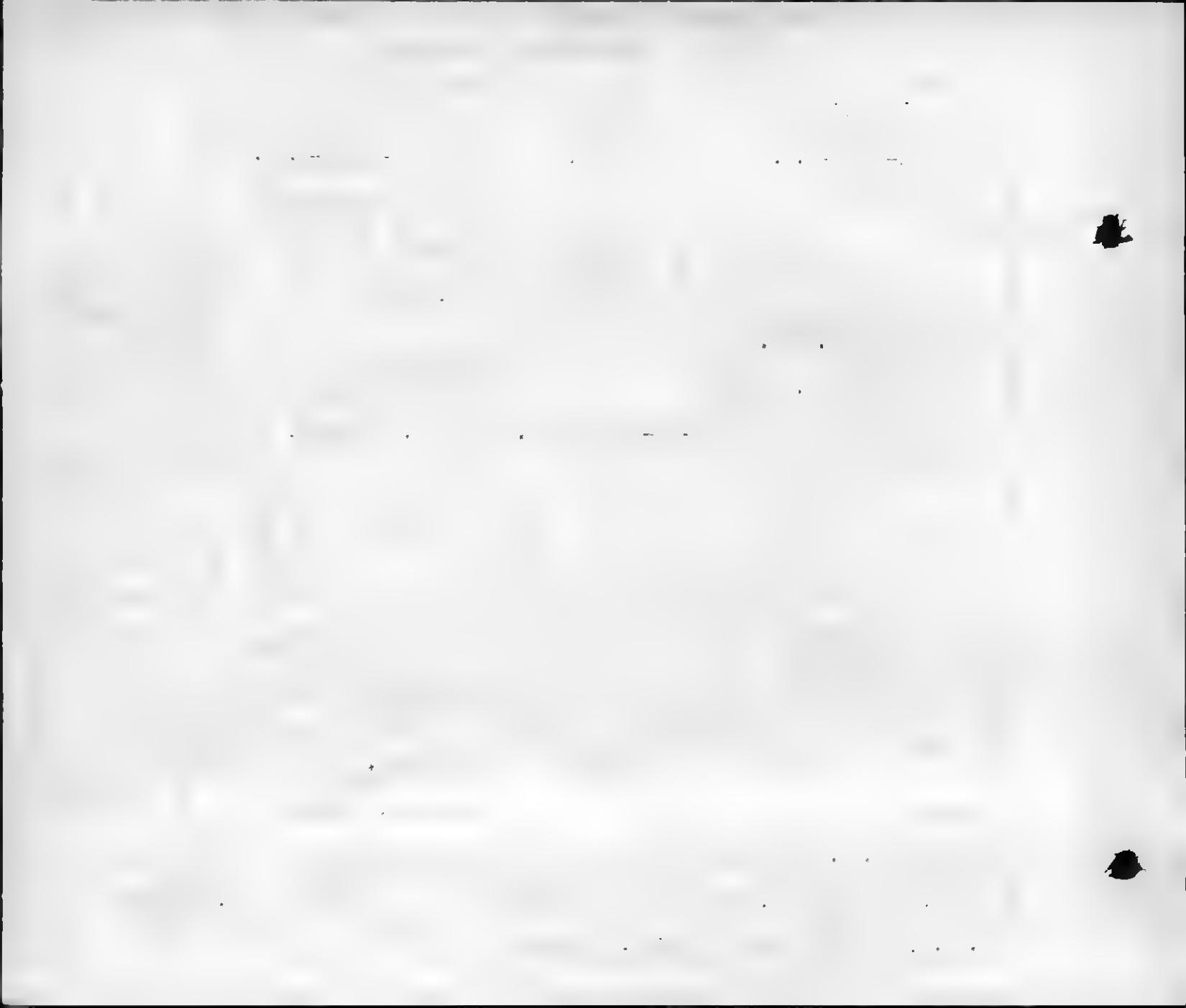
06816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural-R.D.#1		c. LENGTH OF STAY IN 1b 12 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Burkittsville		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural-R. D. #1		
3. NAME OF DECEASED (Type or print) MORRIS		First MORRIS	Middle TRUMAN	
4. DATE OF DEATH June 13, 1958	Month June	Day 13	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1879	
9. AGE (In years from birthday) yrs. 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
13. FATHER'S NAME Daniel T. DeLauter	14. MOTHER'S MAIDEN NAME Martha Mock	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO. 220-28-8963			17. INFORMANT Mrs. Rachel K. DeLauter, Same as Item #1	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) <i>Cardio - renal - Vascular disease</i> <i>Advanced Arterio Sclerosis -</i>				INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 8, 1958 to June 13, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>J. Elmer Harp</i>	M.D. Middletown, Maryland			ADDRESS (Street, city or town, state) Middletown Md
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp				DATE SIGNED 6/14/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery	22d. LOCATION (City, town, or county) Middletown, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland	24a. REC'D BY REGISTRAR DATE JUN 1 1958	24b. REGISTRAR'S SIGNATURE <i>Etchison</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transtil permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6821

CERTIFICATE OF DEATH

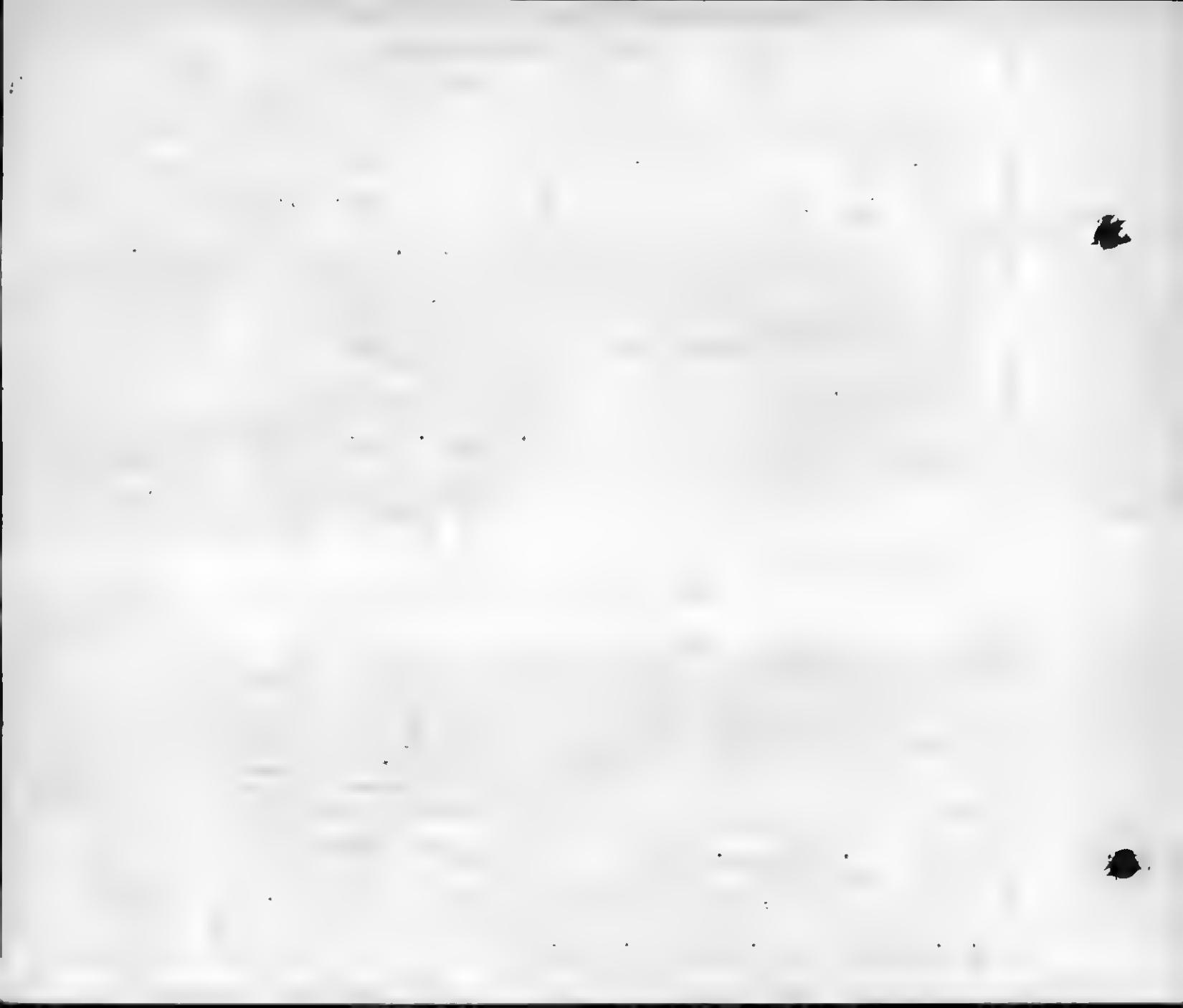
Reg. Dist. No.

06817

TO HOSPITAL OR ATTENDING PHYSICIAN: Fill in required information. This certificate may be filed with the funeral director by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Maryland Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 East Third Street		e. STREET ADDRESS 24 East Third Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print)	First CHARLES	Middle MOSS	Last DODD, SR.	4. DATE OF DEATH August 24, 1893	Month June	Day 8	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1893	9. AGE (In years from birthday) 64	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed Contractor—Building		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward M. Dodd		14. MOTHER'S MAIDEN NAME Anna Fink					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rosie M. Dodd, Same as item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		<i>Arterio Cardiac Constriction with peritonitis of abdomen Cardiac insufficiency disease Diabetes mellitus</i>				<i>6 days 5 yrs +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <i>June 2, 1958</i> to <i>June 2, 1958</i> , and that death occurred at <i>5:10 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Bernard O. Thomas, M.D.</i>		Professional Building				DATE SIGNED <i>6/10/58</i>	
PHYSICIAN'S NAME (Type) Dr. Berhard O. Thomas		Frederick, Maryland					
22a. BURIAL CREMATION, REMOVED (Specify) Burial		22b. DATE THEREOF June 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 12 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred Finch</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

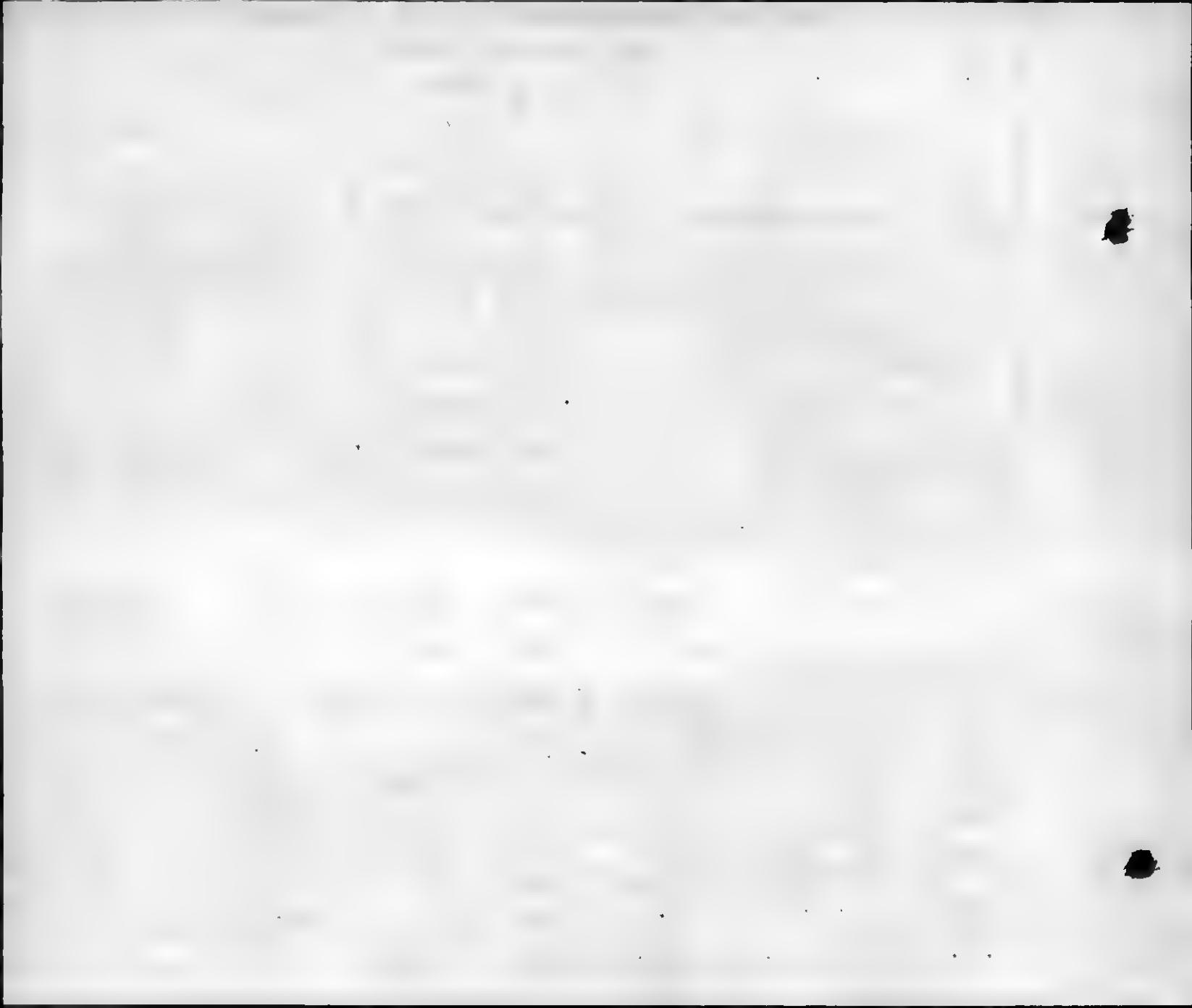
6822

CERTIFICATE OF DEATH

06818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Fredrick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fredrick</i>	c. LENGTH OF STAY IN lb <i>5 Hours</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fredrick</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fredrick Memorial Hosp</i>	d. STREET ADDRESS <i>20 East Second Street</i>		
3. NAME OF DECEASED (Type or print) <i>Catherine Elizabeth</i>	First <i>Duggan</i>	Middle <i></i>	Last <i></i>
4. DATE OF DEATH <i>June 27 1958</i>	Month <i>June</i>	Day <i>27</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>27 June 58</i>
9. AGE (In years last birthday) yrs. <i></i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>William Duggan, Jr.</i>	14. MOTHER'S MAIDEN NAME <i>Mary Jane Etchison</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>William Duggan, Jr. (Same as item #2)</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>761.5</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prematurity</i>			
DUE TO (c) <i>Premature Rupture of membranes</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>27 June, 1958</i> , to <i>27 June, 1958</i> , that I last saw the deceased alive on <i>27 June, 1958</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>A. M. Powell, Jr.</i>	M.D.	<i>220 N. Market</i>	
PHYSICIAN'S NAME (Type) <i>A. M. Powell, Jr.</i>	<i>Frederick, Maryland</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-28-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. John's Cemetery</i>	22d. LOCATION (City, town, or county) <i>Frederick, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 1 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred Etchison</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06819

6845

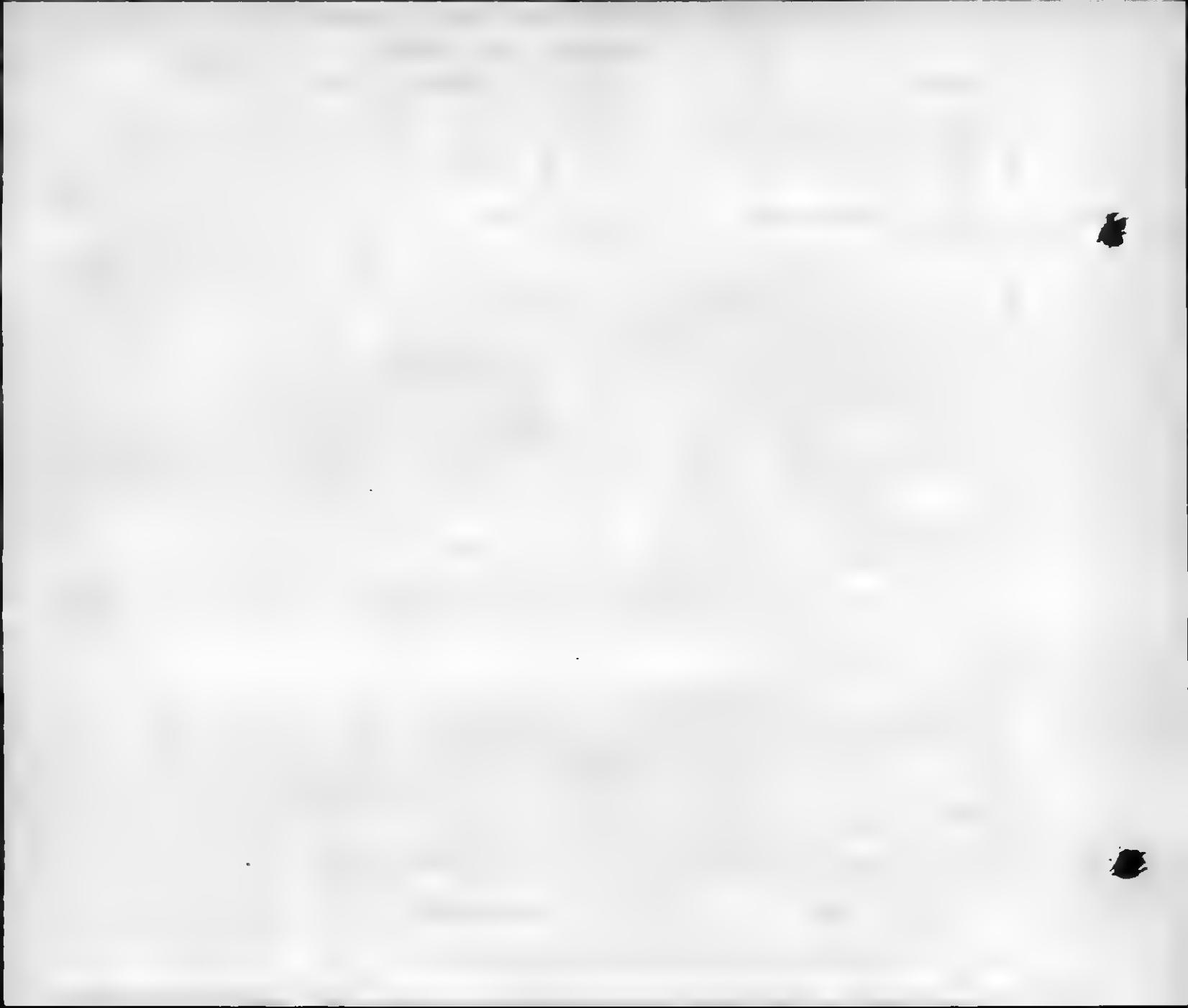
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Olive	Middle E.	Last Eckard	4. DATE OF DEATH	Month 6	Day 4	Year 1958
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1897		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William L. Guyton		14. MOTHER'S MAIDEN NAME Loretta Beachley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Amidee E. Eckard, Middletown, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middletown	(County) Maryland (State) Md.	
21. I certify that I attended the deceased from June 4, 1958 , to June 4, 1958 , that I last saw the deceased alive on June 4, 1958 , and that death occurred at 6 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 6-5-58		
ACTUAL Elmer Harp								
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/6/1958		22c. NAME OF CEMETERY OR CREMATORIUM Pleasant View Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR JUN 9 '58		24b. REGISTRAR'S SIGNATURE Elmer Harp		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06820

6846

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lemmitsburg rural

c. LENGTH OF STAY IN 1b

15 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lemmitsburg--- rural St. Anthony

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First Robert H. Fury

Last

4. DATE
OF
DEATH
June 15 1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED DIVORCED

8. DATE OF BIRTH

1884

9. AGE (In years
from birthday)
yrs.

74

10. IF UNDER 1 YEAR
Months Days Hours Min.

11. IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done
During most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Contracter

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Fury

14. MOTHER'S MAIDEN NAME

Edna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

216-01-(386)

17. INFORMANT

Roland Lauterback Ellicott City RD 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420. i Acute Coronary Occlusion -

INTERVAL BETWEEN
ONSET AND DEATH

1 minute

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

(b)

DUE TO

(c)

Arteriosclerosis

years

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 30, 1958 to June 15, 1958, that I last saw the deceased
alive on June 12, 1958, and that death occurred at 3 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Charles R. Williams M.D.

Emmitsburg Md 6/16/58

PHYSICIAN'S
NAME (Type)

Charles R. Williams

22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial

6-17-58

United Brethren Com/

Thurmont, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Crager Thurmont, Md.

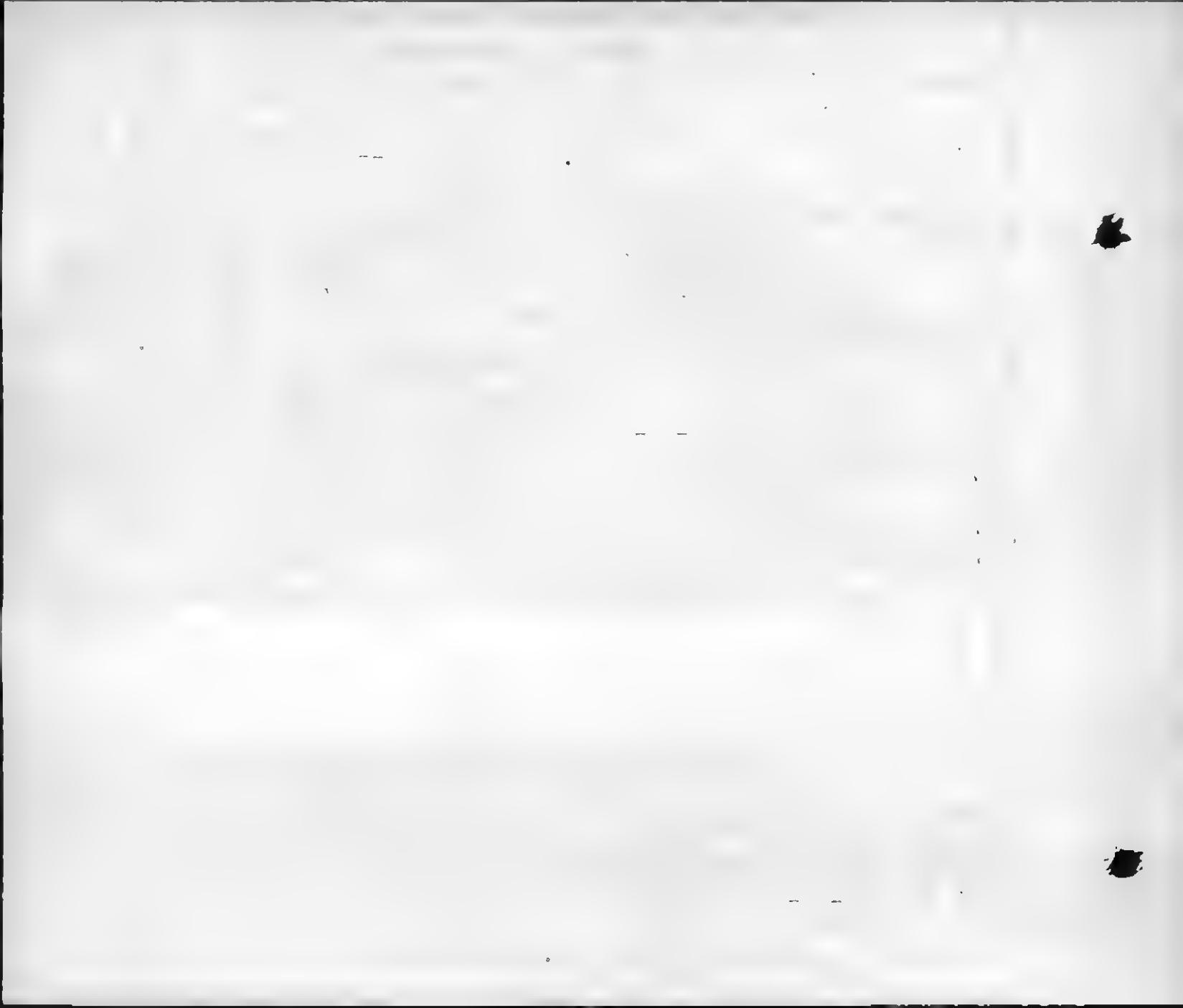
ADDRESS

24a. REC'D BY REGISTRAR

DATE JUN 17 1958

24b. REGISTRAR'S SIGNATURE

Allie French



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06821

6823

CERTIFICATE OF DEATH

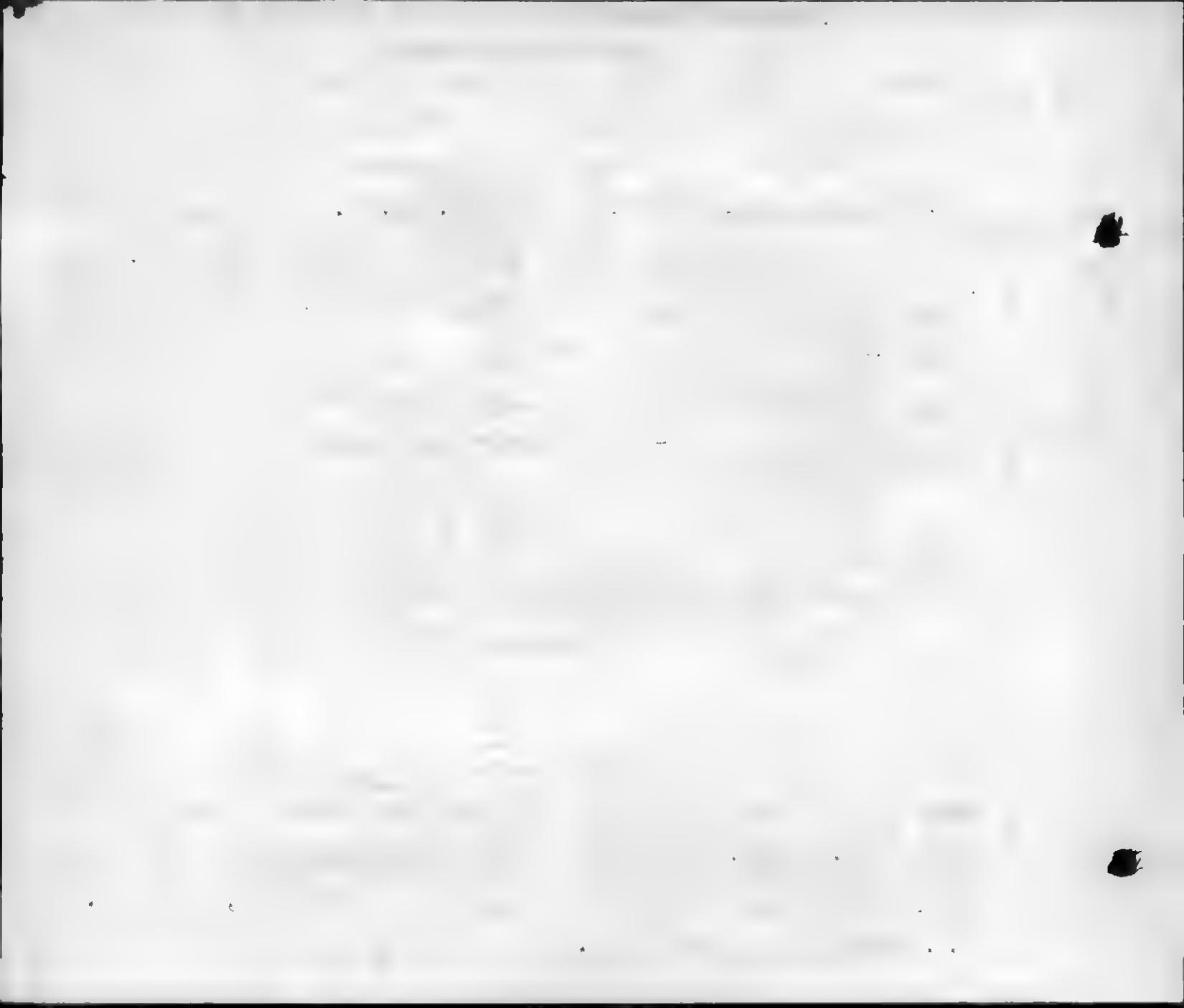
Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) WILLIAM CALVIN GEESY		4. DATE OF DEATH June 29, 1958	Month Day Year Month Days Hours Min.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 31, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Contractor & Builder	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Thomas Geesey		14. MOTHER'S MAIDEN NAME Alice Snook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-12-0598	17. INFORMANT Miss Beatrice Geesey (same as item #2)
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a) Cerebrovascular thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. b) Generalized arterio sclerosis DUE TO b) Acute myocardial infarct INTERVAL BETWEEN ONSET AND DEATH 10 Min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 22, 1958 , to June 29, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at 9:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Shopping Center			
ACTUAL SIGNATURE <i>Ralph L. Michels</i>		DATE SIGNED 7/1/58	
PHYSICIAN'S NAME (Type) Dr. Ralph L. Michels		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF July 3, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Methodist Cemetery	
22d. LOCATION (City, town, or county) Leikstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M.R.Etchison & Son, Frederick, Md.		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
		24b. REGISTRAR'S SIGNATURE <i>R. Etchison</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06822

6824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 635 Park Place		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 635 Park Place						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First BERNARD	Middle LEE	Last GILBERT, SR.	4. DATE OF DEATH	Month June	Day 17,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 26 Sept 1899	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Brush Company		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James M. Gilbert				14. MOTHER'S MAIDEN NAME Rosa Mattoon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2115		17. INFORMANT Mrs. Mary H. Gilbert (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Severe excretory imbalance</i>		INTERVAL BETWEEN ONSET AND DEATH 1 week				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b)		DUE TO <i>Generalized carcinomatosis</i>		1 year				
(c)		<i>Primary carcinoma of descending colon</i>		8 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Walkersville, Maryland	(County)	(State)		
21. I certify that I attended the deceased from <u>June 16</u> , 1958, to <u>June 17</u> , 1958, that I last saw the deceased alive on <u>June 16</u> , 1958, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. A. Dettbarn</u>				ADDRESS (Street, city or town, state)		DATE SIGNED 6-17-58		
PHYSICIAN'S NAME (Type) E. A. Dettbarn, M. D.								
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town or county) Frederick, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JUN 20 '58	24b. REGISTRAR'S SIGNATURE <u>John E. Etchison</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06823

Reg. Dist. No.

6847

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg R.F.D. 2		c. LENGTH OF STAY IN lb 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg Emmitsburg R.F.D. 2		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lucy		First Middle Last Estelle Glass		4. DATE OF DEATH June 29		Month Day Year 19 58	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper hanger		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Lee Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Davis				14. MOTHER'S MAIDEN NAME Lucy Burke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-22-8413		17. INFORMANT Paul E. Glass, Emmitsburg, R.F.D. 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416 DUE TO Chronic Rheumatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO heart disease with (c) Pulmonary Edema							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>B.O. Thomas</i>				DATE SIGNED 6/30/58			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORIUM Silver Leaf Cemetery		22d. LOCATION (City, town, or county) Rose Hill, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager Thurmont, Md.				ADDRESS		24a. REC'D BY REGISTRAR JUL 2 '58	
						24b. REGISTRAR'S SIGNATURE <i>W.L. French</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PHA3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

06824

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 6846 FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Fre derick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ladiesburg Rural		c. LENGTH OF STAY IN lb 4 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF -DECEASED (Type or print) BRUCE		First O	Middle HARBAUGH	4. DATE OF DEATH June 25	Month Day Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 31 - 1894	9. AGE (in years less birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Washington Harbaugh		14. MOTHER'S MAIDEN NAME Susan Working		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-3e-3256		17. INFORMANT Mrs. Mary A. H arbough Ladiesburg MD	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH Minutes					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/26/1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/1958		22c. NAME OF CEMETERY OR CREMATORIALy Glade	
22d. LOCATION. (City, town, or county) Walkersville		(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE G. C. Barton		ADDRESS Walkersville Md		24a. REGISTRY REGISTRAR JUN 30	
				24b. REGISTRAR'S SIGNATURE W. E. Clegg	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please ex-
 cease to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, creation,
 or removal.

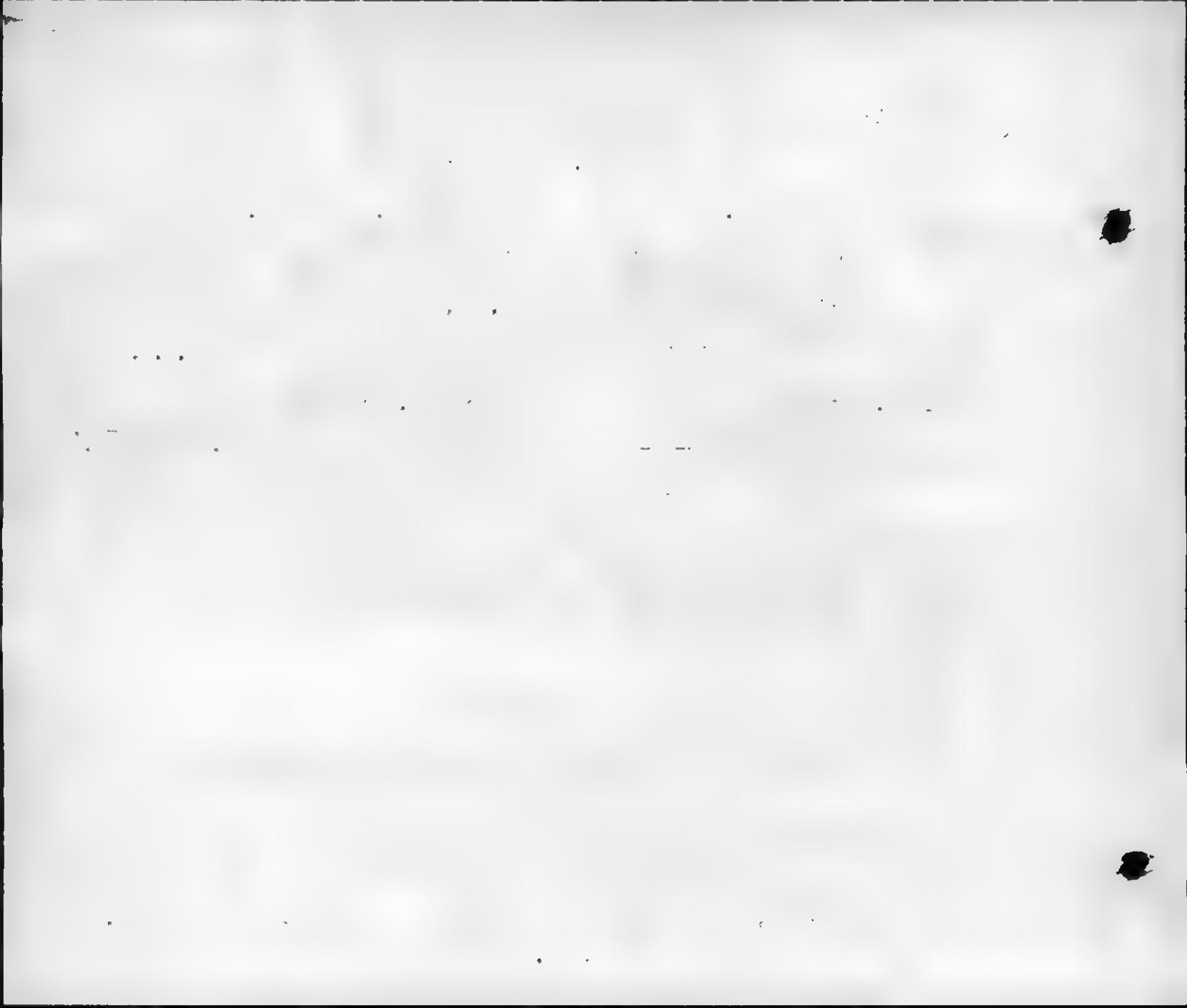
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06825

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Yrs.		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Market & Fourth Sts.				d. STREET ADDRESS 236 A N. Market St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Robert		First Cornelius	Middle Harding	Last	4. DATE OF DEATH June 16 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1912	9. AGE (in years last birthday) 16 yr.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Filling station		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albert. M. Harding		14. MOTHER'S MAIDEN NAME Martha E. Schilling						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 214-10-4347		17. INFORMANT Nettie Jacobs Harding		Address Frederick Md. 236 A N. Market St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis								
DUE TO 4/20, 1								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R.O. Thomas</i>	DATE SIGNED <i>June 19, 1958</i>							
EXAMINER'S NAME (Type) <i>R.O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 20, 1958	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline & Son</i>		ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR DATE JUN 20 '58	24b. REGISTRAR'S SIGNATURE <i>John Edward</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6849

CERTIFICATE OF DEATH

06826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bells Mill Road		d. STREET ADDRESS Bells Mill Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Francis	Last Heffner Sr	4. DATE OF DEATH June 10	Month Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16-1903	9. AGE (in years last birthday) 54	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matinence Frederick Iron & Steel		10b. KIND OF BUSINESS OR INDUSTRY Produce co		10c. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John W. Heffner		14. MOTHER'S MAIDEN NAME Anne Brown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Gertrude Heffner, Knoxville, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma, rt. lung DUE TO 16a.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) pulmonary insufficiencies DUE TO (c) metastasis in brain					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 15 So. Maryland Ave. (County) Brunswick (State) Md.	
21. I certify that I attended the deceased from Mar 22 , 19 58 to June 10 , 19 58 , that I last saw the deceased alive on June 4 , 19 58 , and that death occurred at 7509 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 So. Maryland Ave. DATE SIGNED JUN 16 '58					
ACTUAL SIGNATURE C. T. BYRON KAO		PHYSICIAN'S NAME (Type) C. T. BYRON KAO			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-58		22c. NAME OF CEMETERY OR CREMATORIUM Locust Valley	
22d. LOCATION (City, town, or county) Rural, Burkittsville, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Heath		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE Allen Schuck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06827

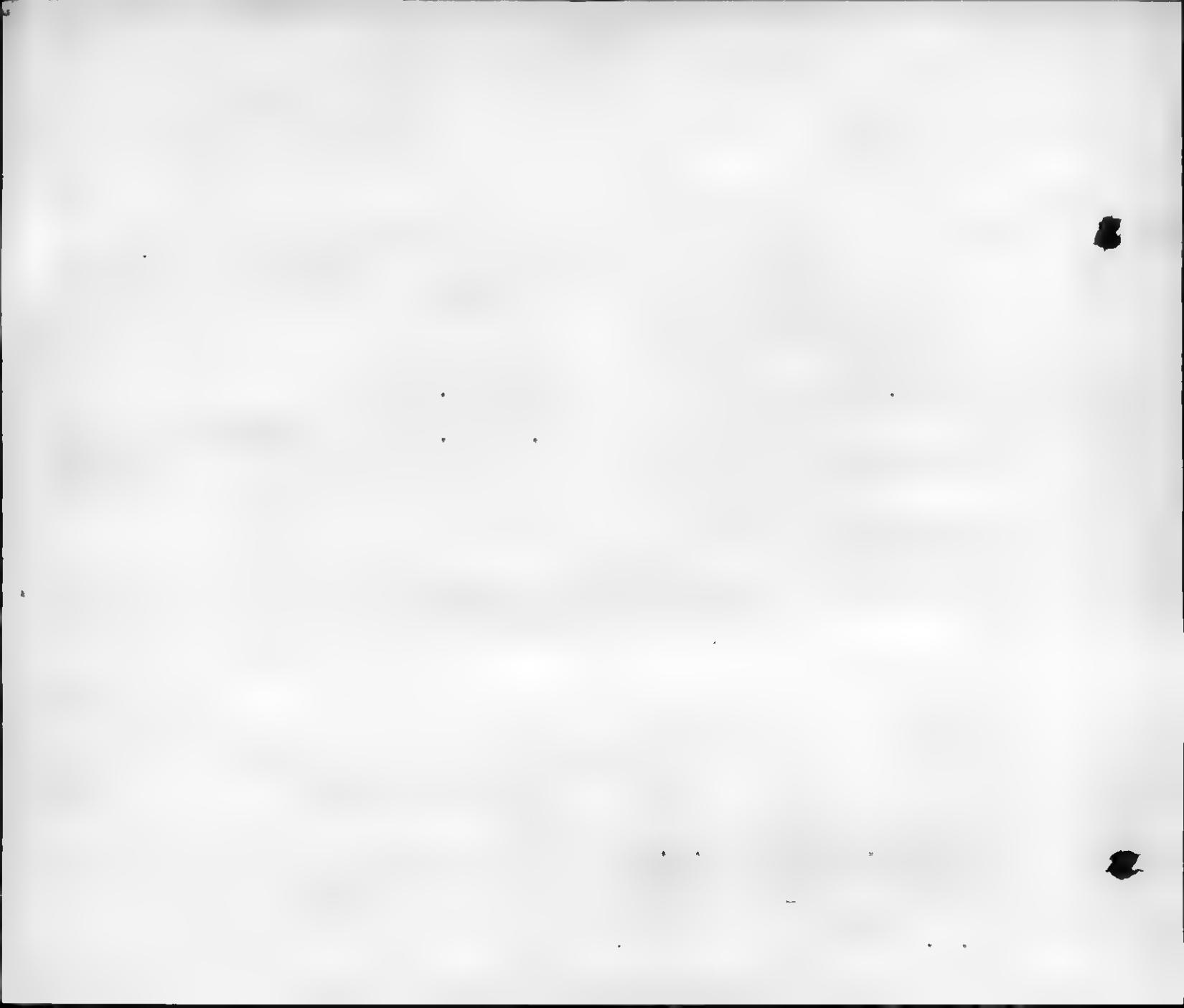
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle THOMAS	Last HEMP	4. DATE OF DEATH	Month June	Day 26,	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 23 Dec 1881	9. AGE (In years last birthday) yr. 76	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Corporation		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert A. Hemp		14. MOTHER'S MAIDEN NAME Jane O. Barger					
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unk		17. INFORMANT Mrs. Emma V. Hemp (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Generalized Arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Middleton, Maryland		(County) (State)	
21. I certify that I attended the deceased from June 26, 1958 , to June 26, 1958 , that I last saw the deceased alive on June 26, 1958 , and that death occurred at Middleton, Maryland P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middleton, Maryland							
ACTUAL SIGNATURE <i>J. Elmer Harp</i>		DATE SIGNED 6/27/58					
PHYSICIAN'S NAME (Type) J. Elmer Harp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE <i>D. Etchison</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



06828

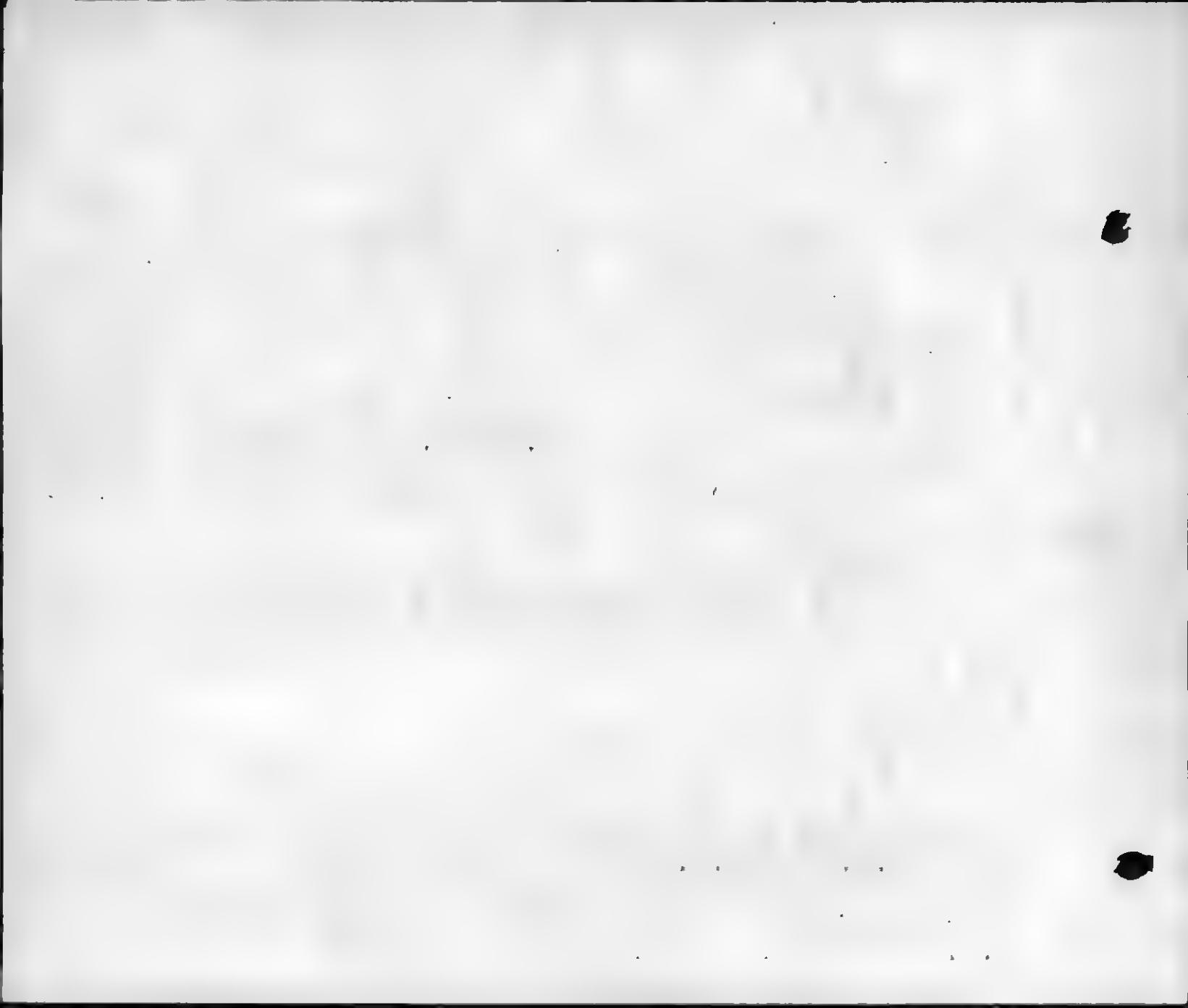
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6851 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2		c. LENGTH OF STAY IN lb 51 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Urbana				d. STREET ADDRESS Urbana		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle OTIS	Last HENDRICKSON	4. DATE OF DEATH June 12, 1958	Month June	Day 12	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1875	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-General Merchandise Business		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ephraim Hendrickson				14. MOTHER'S MAIDEN NAME Cecelia Anderson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Pearl W. Hendrickson (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 16 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED 13 June 1958						
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REG. STAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE <i>Albert E. Etchison</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transtel permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06829

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it at once, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission)				
<i>Fredrick</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Fredrick</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<i>NEGORE</i>	<i>1 DAY</i>	<i>X Le Rose,</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SWBARRICK LIME Co.</i>		STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>Leycester</i> Middle <i>Hillabiddle</i> Last <i>June 18</i>	4. DATE OF DEATH Month <i>Month</i> Day <i>Day</i> Year <i>Year</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>July 16 1899</i>			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years) <i>58 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>QUARRY</i>	11. BIRTHPLACE (State or foreign country) <i>Fredrick Co</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>						
13. FATHER'S NAME <i>Frank Hillabiddle</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Baugher</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>213-16-0115</i>	17. INFORMANT <i>Informant Hillabiddle</i>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Coronary Thrombosis</i>				
44d 0-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO				
		DUE TO (c)				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>WOODSBORO</i>	(County) <i>M.D.</i>	(State) <i>M.D.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>B.C. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>June 18, 1958</i>		
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/21/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. HOPE CEM. WOODSBORO M.D.</i>	22d. LOCATION (City, town, or county) <i>WOODSBORO M.D.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Powell & Hartzler, Woodsboro Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>John 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John 20 '58</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06830

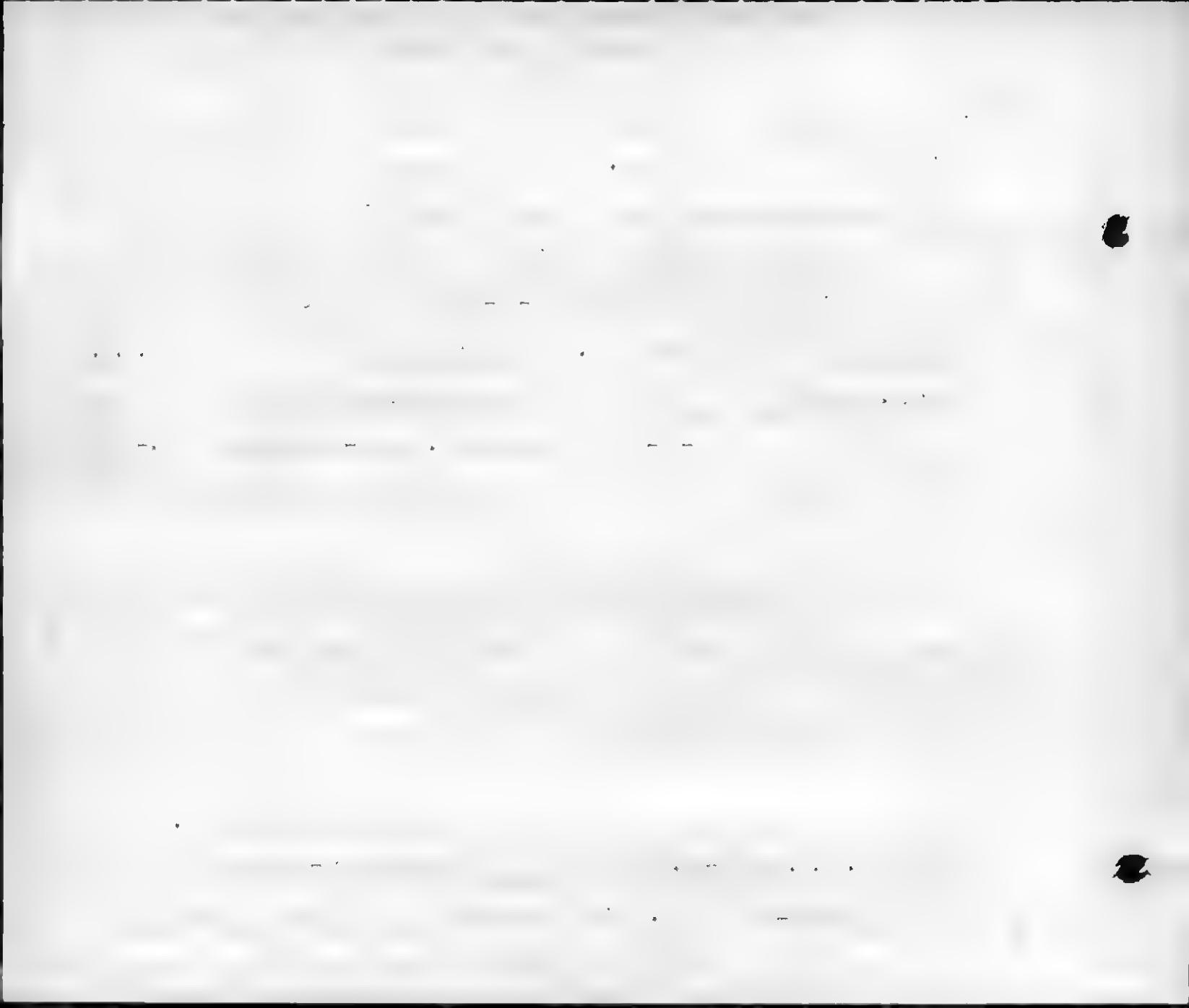
6826 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE							
Frederick MARYLAND		Maryland Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY							
Frederick	35 yrs.	Frederick							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
110 Catoctin Avenue	110 Catoctin Avenue								
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
	Amy	Irene	Kinna	June	2	19	58		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
Female	White		8-11-1895	62 yrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Seamstress		Tailoring Co.		Maryland		U.S.A.			
13. FATHER'S NAME									
Enos L. Mayne									
14. MOTHER'S MAIDEN NAME									
Susie Elizabeth Shankle									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		217-10-9252		Miss Irene V. Kinna-110 Catoctin Ave.-Frederick		Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Hypertension</i>									
DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>									
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <i>4-1</i> , 19 <i>50</i> , to <i>5-1</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-1</i> , 19 <i>58</i> , and that death occurred at <i>IP</i> M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
DATE SIGNED									
ACTUAL SIGNATURE <i>U.G. Bourne Jr.</i>									
M.D. <i>30 West All Saints St.</i>									
PHYSICIAN'S NAME (Type)		Frederick-Maryland							
Dr. U.G. Bourne-Jr.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Burial		June 5 1958		Mt. Olivet Cemetery		Frederick		Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		W. ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 5 '58		24b. REGISTRAR'S SIGNATURE			
<i>C.E. Cline & Son</i>		Frederick Maryland				<i>Officer</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06831

6827

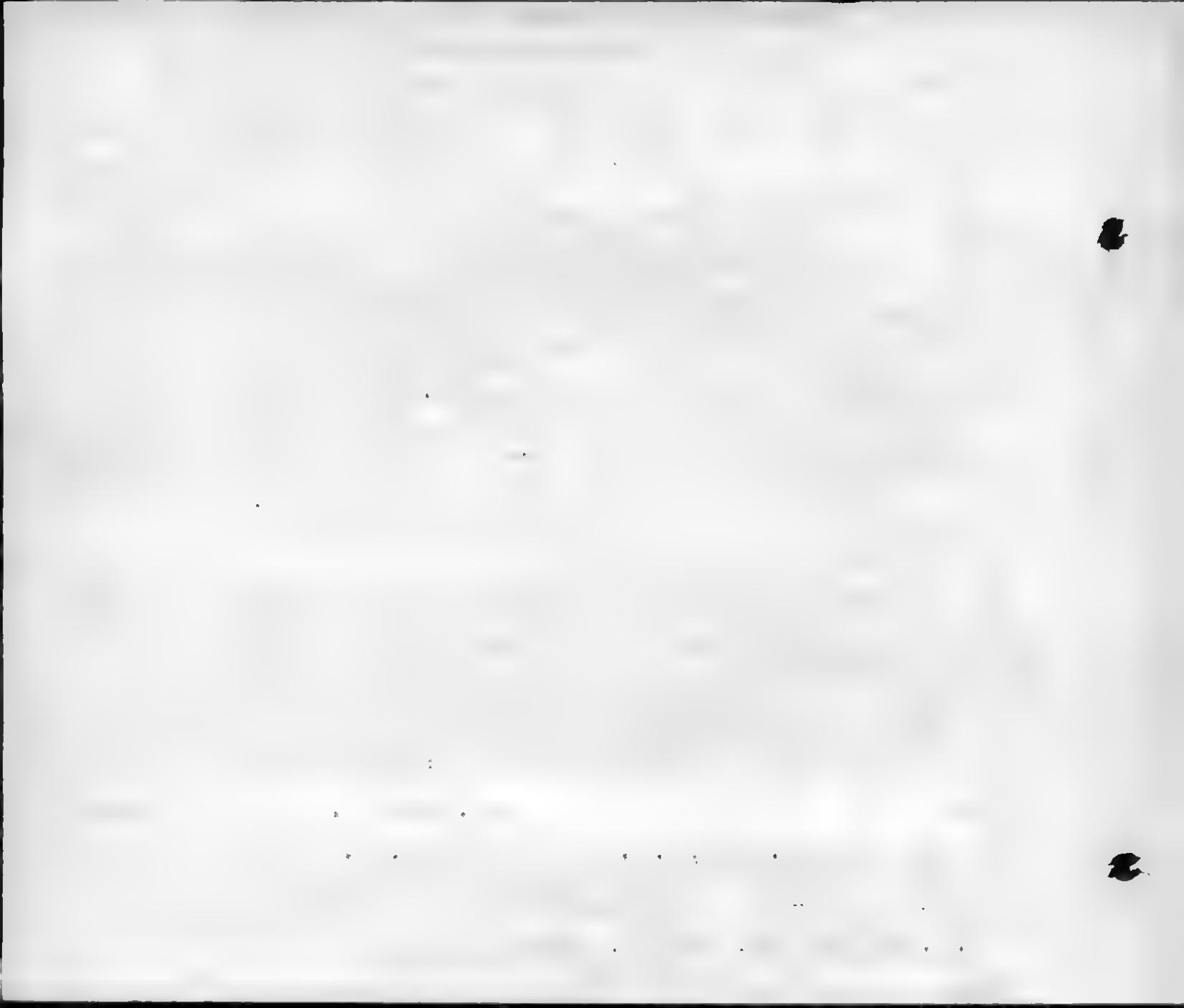
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 3/5/53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy	
3. NAME OF DECEASED (Type or print) ARTHUR SIMPSON		4. DATE OF DEATH Month June Day 9, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 20 April 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Justice of Peace	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Reuben Kolb		14. MOTHER'S MAIDEN NAME Sarah A. Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Same As Item #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4. Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Atherosclerosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-21-58 to 12-21-58 , that I last saw the deceased alive on 12-21-58 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE J.W. Etchison M.D. 4 E. Church St. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 6-11-58			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-58	
22c. NAME OF CEMETERY OR CREMATORIUM McKendree Cemetery		22d. LOCATION (City, town, or county) Howard County Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
		24b. REGISTRAR'S SIGNATURE W. Etchison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 3 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06832

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. LENGTH OF STAY IN lb Life		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
3. NAME OF DECEASED (Type or print)		First Teresa		Middle Lynn		Last Long		4. DATE OF DEATH Month June		Day 29	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1958		9. AGE (in years last birthday) 425		10. IF UNDER 1 YEAR Months 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		11. IF UNDER 24 HRS. Days 25		Hours Min.	
13. FATHER'S NAME Leo Miller		14. MOTHER'S MAIDEN NAME Marcaline Long		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 724.0 DUE TO Conditions, if any, which gave rise to immediate (a), stealing the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
						<i>Accidental Suffocation</i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of item 18) Baby was in night face down the face was in side of mattress & side of cr b mattress did not fit tight against		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) Home		20f. (City or town) Myersville	
										(County) (State) Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 30, 1958							
EXAMINER'S NAME (Type) B. O. Thomas											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Zion Lutheran		22d. LOCATION (City, town, or county) Middletown, Fred. Co. Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>		ADDRESS Paul F. Bittle Myersville, Md.		24a. REC'D BY REGISTRAR JUL 2 1958		24b. REGISTRAR'S SIGNATURE <i>Alt. Redrich</i>		DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar, or prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06833

6828

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First QUINCY	Middle THEODORE	Last LOWERY	4. DATE OF DEATH	Month June	Day 2,	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 30 Aug 1897	9. AGE (In years last birthday) 60 yr	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Western Union		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Lowery		14. MOTHER'S MAIDEN NAME Laura Pomeroy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 091-07-6094		17. INFORMANT Mrs. Lena Lowery (Same as item #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiacus</i> <i>7 Jan 58</i>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) <i>It was due to inferior circulation 26 hrs</i>		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 31, 1958</i> to <i>July 2, 1958</i> that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>7:05 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <i>3 June 1958</i>	
ACTUAL SIGNATURE <i>E.P. Thomas, M.D.</i>							
PHYSICIAN'S NAME (Type) E. P. Thomas, M. D.		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-58		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		22d. LOCATION (City, town, or county) Point of Rocks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		ADDRESS M. R. Etchison and Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 1958 4 159		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Loge 4
 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06834

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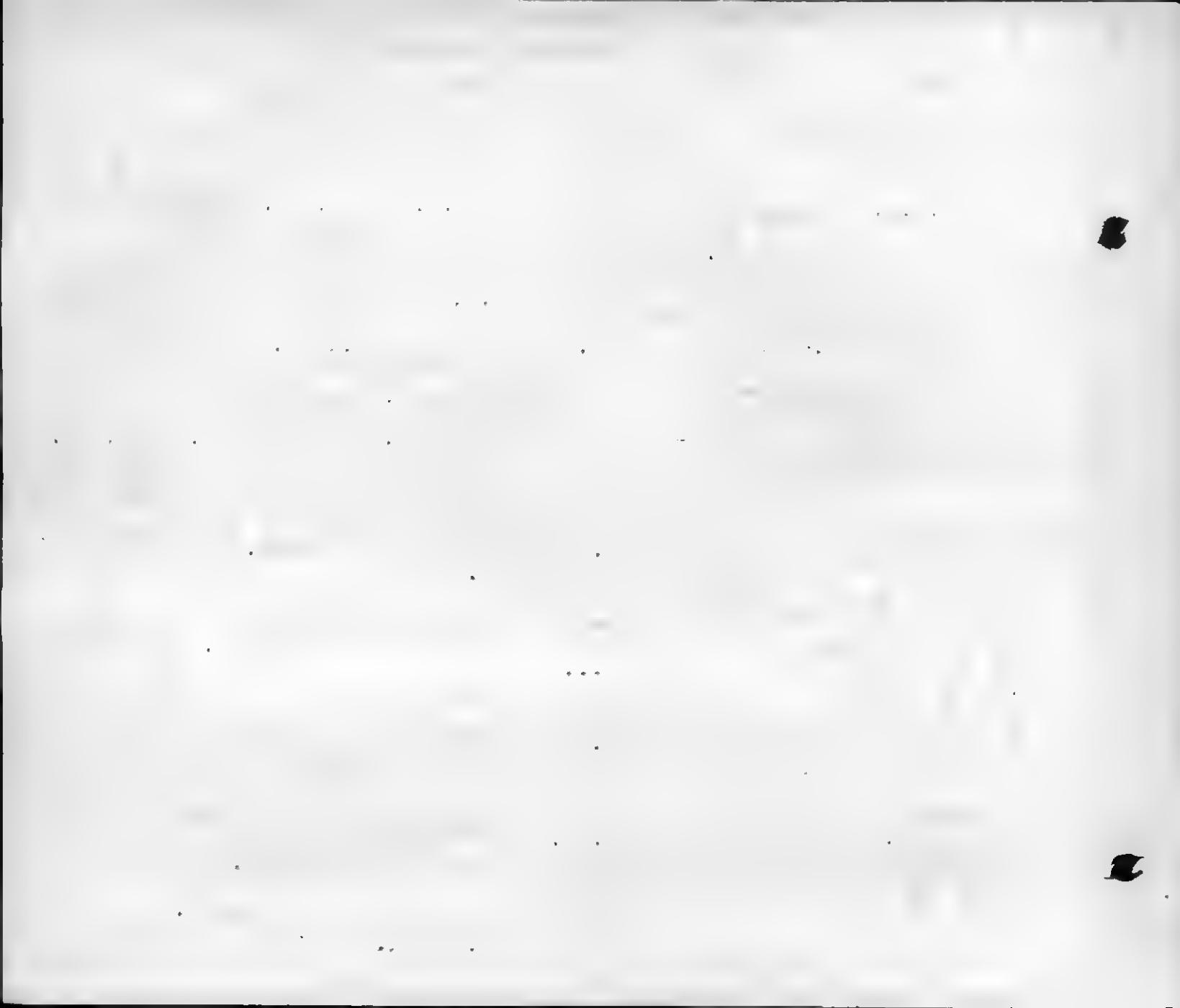
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bartholows		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bartholows					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 1, Mt. Airy		d. STREET ADDRESS R.F.D. # 1, Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Roy W. Lugenbeel		First	Middle	lost	4. DATE OF DEATH June 18	Month	Day	Year 19 58	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - B. & O. Railroad Co.		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co., Md.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Lugenbeel		14. MOTHER'S MAIDEN NAME Effie B. Beach		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 215-05-2370			
17. INFORMANT Mrs Evelyn M. Lugenbeel, Mt. Airy, Md.		18. ADDRESS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Thrombosis with Myocardial Infarction. Auricular Fibrillation. (c) DUE TO Bundle branch block.				INTERVAL BETWEEN ONSET AND DEATH Immediate					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thyrotoxicosis (Adenoma of thyroid) Thyroidectomy									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No Injury...		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Druid Theatre Building	
								(County) 6/19/58 (State)	
21. I certify that I attended the deceased from Nov. 2, 1957 , to June 18, 1958 , that I last saw the deceased alive on May 27, 1958 , and that death occurred at 11:30 AM from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 9830 Main Street		DATE SIGNED 6/19/58	
ACTUAL SIGNATURE M. McKendree Boyer, M. D.									
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Morgan Chapel		22d. LOCATION (City, town, or county) Woodbine, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		ADDRESS Danascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 23 '58		24b. REGISTRAR'S SIGNATURE Alfred Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



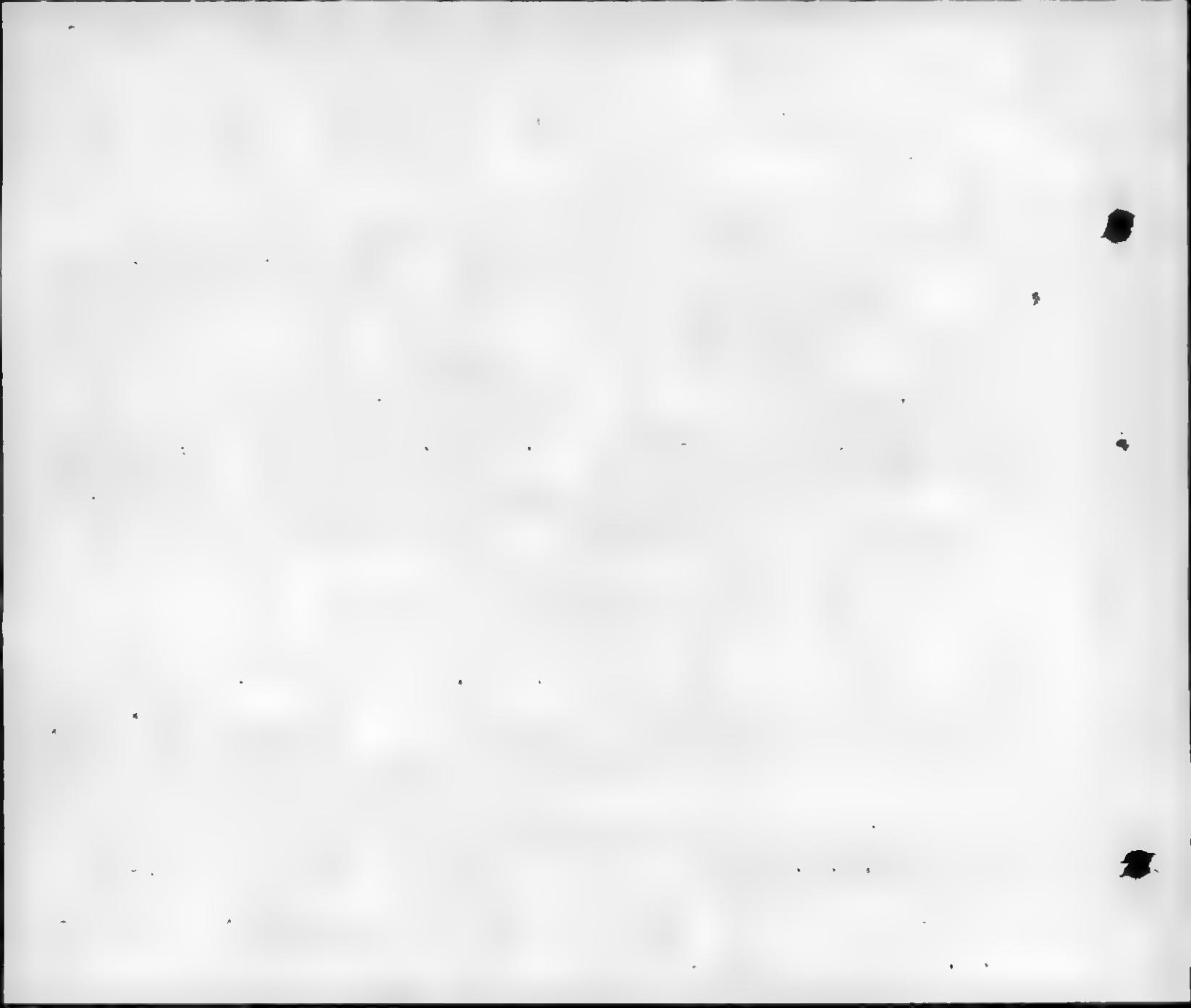
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Urbana	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #355		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle VERNON	Last MANION
4. DATE OF DEATH	Month June	Day 7,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 9, 1899
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE In years (at birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James O. Manion		14. MOTHER'S MAIDEN NAME Annie E. Carlisle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 578-07-3050	
17. INFORMANT		Address Mr. James M. Carlisle, Dickerson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Base Skull INTERVAL BETWEEN ONSET AND DEATH Instant			
3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed Chest			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Struck Culvert on Rt. #355, Near Urbana, Maryland			
20c. TIME OF INJURY Month, Day, Year 8:00 p.m. June 7 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Road 20f. (City or town) Co. Urbana (Near) Frederick, Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED 6/9/1958	
EXAMINER'S NAME (Type) Dr. B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 10, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery	22d. LOCATION (City, town, or county) Beallsville, (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland		ADDRESS	24a. REC'D BY REGISTRAR
			DATE JUN 12 '58
			24b. REGISTRAR'S SIGNATURE <i>W. L. Burdette</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06836

6829

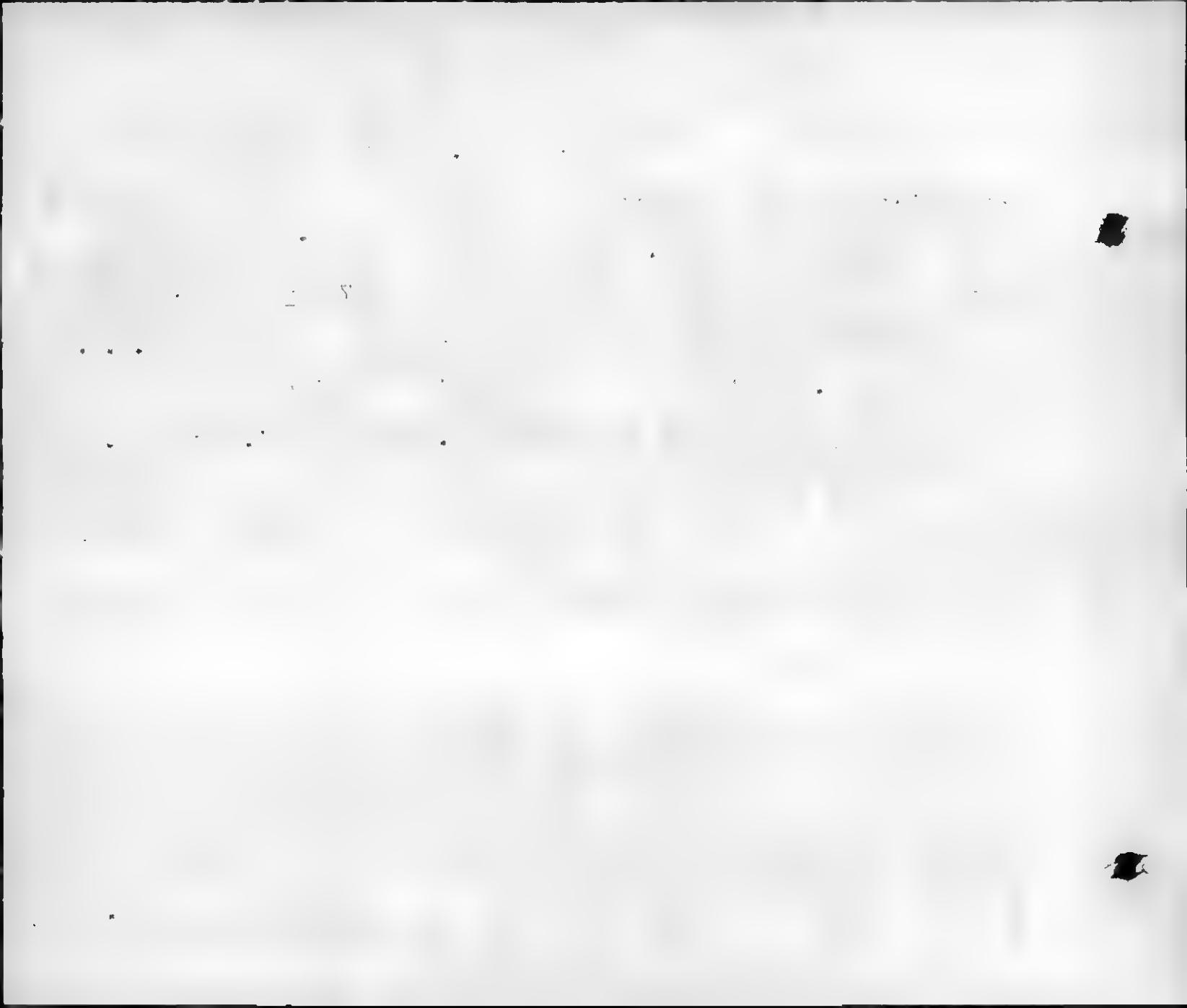
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Lillian	Middle J.	Last Martin	4. DATE OF DEATH	Month June Day 25 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lrb birthday yrs.)	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles C. Duvall		14. MOTHER'S MAIDEN NAME Mammie Burris		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Mammie C. Duvall Address Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uterine</i>				INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
111X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Obstruction of uterus</i> DUE TO (c) <i>Carcinoma of the cervix with local metastases</i>				2-3 mo. 18-24 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>5/21</u> , 1958, to <u>6/25</u> , 1958, that I last saw the deceased alive on <u>6/25</u> , 1958, and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE	<i>Henry V. Chase</i>		M.D.	<i>4 E. Church St</i>	<i>6/25/58</i>
PHYSICIAN'S NAME (Type)	<i>Henry V. Chase</i>			<i>Frederick Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 27	22c. NAME OF CEMETERY OR CREMATORIUM Damascus	22d. LOCATION (City, town, or county) Damascus	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barber</i>		ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR JUN 30 1958 DATE	24b. REGISTRAR'S SIGNATURE <i>John Barber</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6830 CERTIFICATE OF DEATH

Reg. Dist. No.

06837

1. PLACE OF DEATH o. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	c. LENGTH OF STAY IN lb	b. COUNTY <i>Carroll</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>	d. STREET ADDRESS <i>RFD #4</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Joyce Arcene</i>	First <i>Joyce</i>	Middle <i>Arcene</i>	Last <i>May</i>
4. DATE OF DEATH <i>May 6 1958</i>	Month <i>May</i>	Year <i>1958</i>	Day <i>6</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6/21/58</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years lost birthday) yrs. <i>6</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md</i>
			12. CITIZEN OF WHAT COUNTRY? <i>None</i>
13. FATHER'S NAME <i>Ralph Augusta May Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Savoy Cobright</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war & dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Chloroform</i>			
DUE TO <i>Pneumaturity</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/21/58</i> , 19 <i>58</i> , to <i>6/24/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/24/58</i> , 19 <i>58</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank J. Heldrich Jr.</i> PHYSICIAN'S NAME (Type) <i>FRANK J. HELDRICH JR.</i>		(Street, city or town, state) <i>Baltimore, Md.</i> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-26-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>WESTMINSTER CEM. WESTMINSTER MD.</i>
22d. LOCATION (City, town, or county) <i>WESTMINSTER MD.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>David L. Burkard Westminster, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6-26-58</i>	24b. REGISTRAR'S SIGNATURE <i>D. L. Burkard</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6831

CERTIFICATE OF DEATH

06838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 36 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights Rt.#5 Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Rt. #5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First KENNETH	Middle L.	Last METCALF
4. DATE OF DEATH	Month June	Day 28	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1897
9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR 0 months	11. IF UNDER 24 HRS 26 hours	12. IF UNDER 24 HRS 0 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Superintendent for Chestnut Farms		11. BIRTHPLACE (State or foreign country) Fillmore N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Clayton A. Metcalf		14. MOTHER'S MAIDEN NAME Floy Lathrop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1932		16. SOCIAL SECURITY NO. 578-03-5219	
17. INFORMANT Richard M. Metcalf (Son) Rt.#5 Frederick, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver and intestines		INTERVAL BETWEEN ONSET AND DEATH 1 year	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		3 M.G.D.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 June 1958 to 23 June 1958 , that I last saw the deceased alive on 23 June 1958 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Conley, Jr.		ADDRESS (Street, city or town, state) 1100 E. 22nd Street, Frederick, Md.	
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.		DATE SIGNED 6/30/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Conley, Jr. Frederick, Md.		24a. REC'D BY REGISTRAR DATE JUL 3 '58	
		24b. REGISTRAR'S SIGNATURE Alvarez	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6832

CERTIFICATE OF DEATH

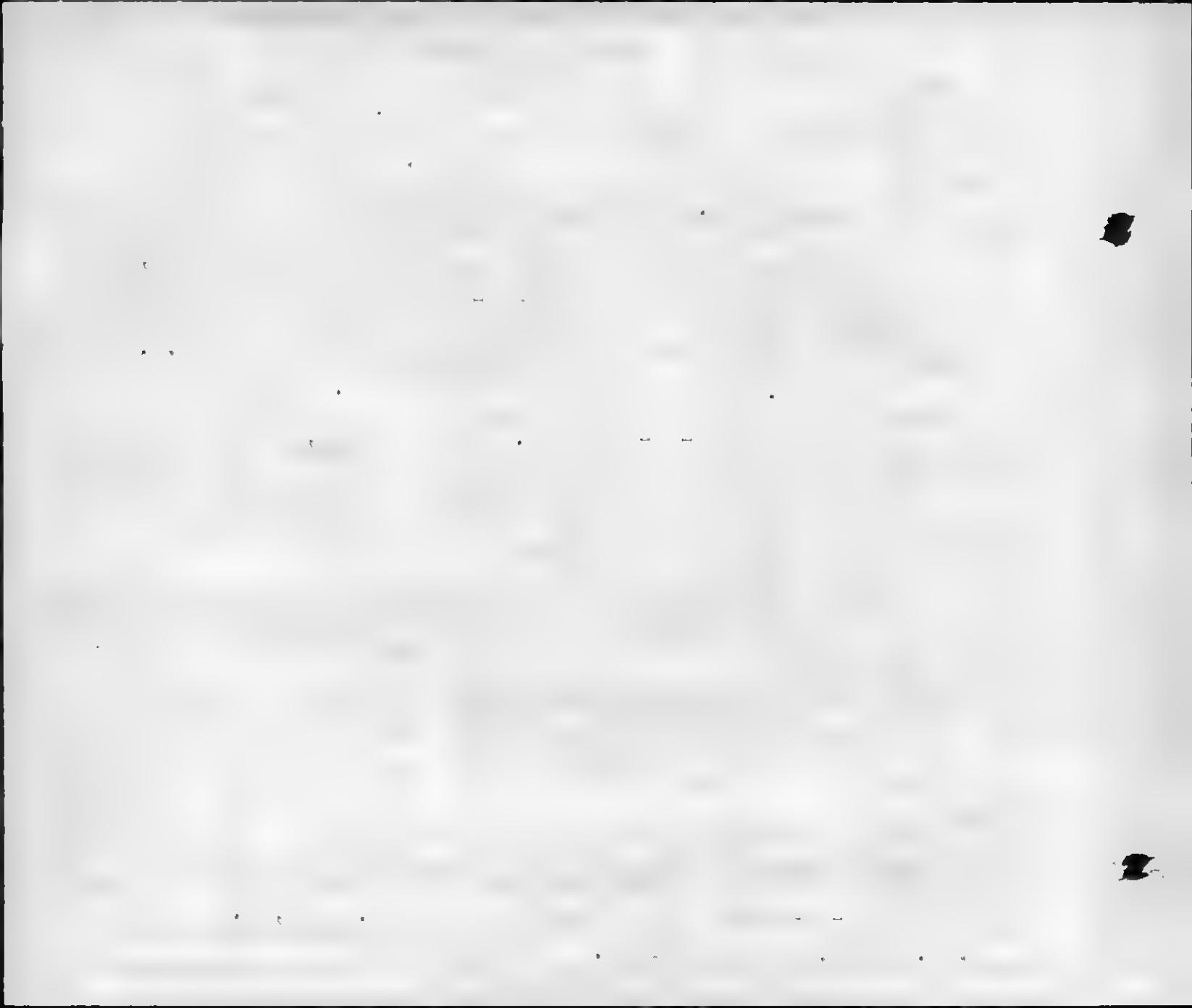
06839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 2 wks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital	d. STREET ADDRESS Hood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD NORWOOD	First	Middle	Last	4. DATE OF DEATH JUNE 11, 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2-25-1890	9. AGE (In years last birthday) 08 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic retired		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Jesse F. Norwood		14. MOTHER'S MAIDEN NAME Margaret E. Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-18-0238		17. INFORMANT Mrs. Viola Norwood, Same		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) DUE TO (c)		Subacute Bacterial endocarditis		INTERVAL BETWEEN ONSET AND DEATH 2 mo.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Hypertension of the liver 2. Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 5/28, 1958, to 6/11, 1958, that I last saw the deceased alive on 6/4, 1958, and that death occurred at 10:35 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Henry V. Chase M.D. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 6/11/58						
PHYSICIAN'S NAME (Type) Henry V. Chase		22c. NAME OF CEMETERY OR CREMATORIAL Pine Grove		22d. LOCATION (City, town, or county) Mt. Airy, Md. (State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-14-1958	22c. NAME OF CEMETERY OR CREMATORIAL Pine Grove		22d. LOCATION (City, town, or county) Mt. Airy, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 13 '58	24b. REGISTRAR'S SIGNATURE Audrey Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06840

6856

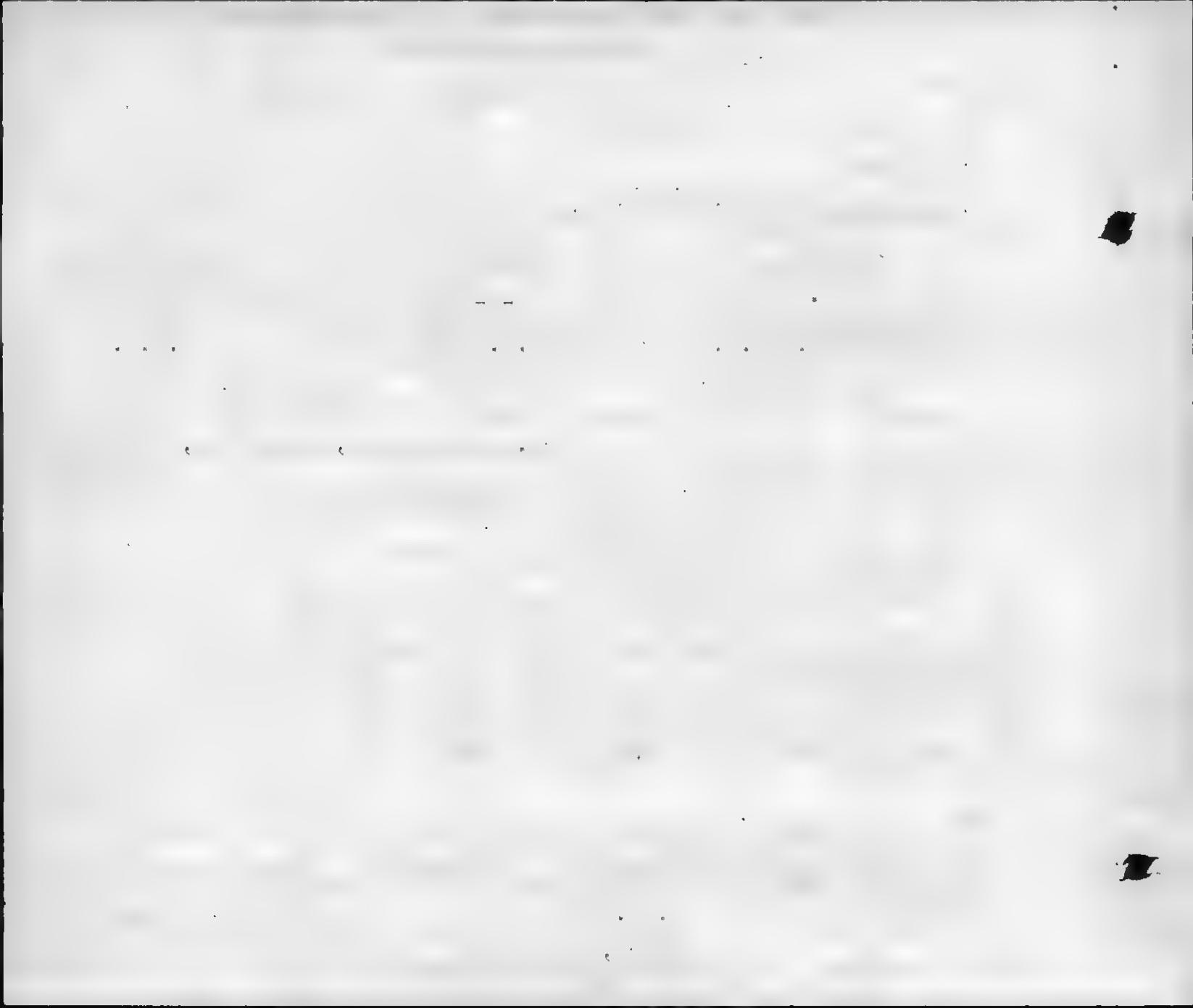
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick		c. LENGTH OF STAY IN b. on highway route 340 Enroute to Hospital in Ambulance	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION on highway route 340 Enroute to Hospital in Ambulance		e. STREET ADDRESS 10 West "I2 (Eye)	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William	First E.	Middle Onley	4. DATE OF DEATH 6 Month 19 Day Year 1958
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1887
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tally B.&R.R.Co Transfer D.C.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry Onley		14. MOTHER'S MAIDEN NAME Sarah Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lottie Onley, Brunswick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Essential Hypertension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/19 , 19 58 , to 6/19 , 19 58 , that I last saw the deceased alive on 6/19 , 19 58 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St	
PHYSICIAN'S NAME (Type) Henry V. Chase		DATE SIGNED 6/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-58	
22c. NAME OF CEMETERY OR CREMATORIAL A. Methidest		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Albert Edward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Calvin Rice

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6857

CERTIFICATE OF DEATH

Reg. Dist. No.

06841

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountaintdale		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont-- rural RD 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First William	Middle Calvin	Last Rice	4. DATE OF DEATH	Month June	Day 25	Year 1958
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1897	9. AGE (In years (at birthday) 61 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY Ox Fiber Brush Co.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME William H. Rice	14. MOTHER'S MAIDEN NAME Anna Sulcer
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 14-10-1849	17. INFORMANT Mrs. Mary E. Rice	Address Thurmont, Md. RD
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Parkinson's Disease	INTERVAL BETWEEN ONSET AND DEATH 3-6 yrs
DUE TO Candidias, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Jaundice, cause undetermined	2 months
DUE TO (c)	

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
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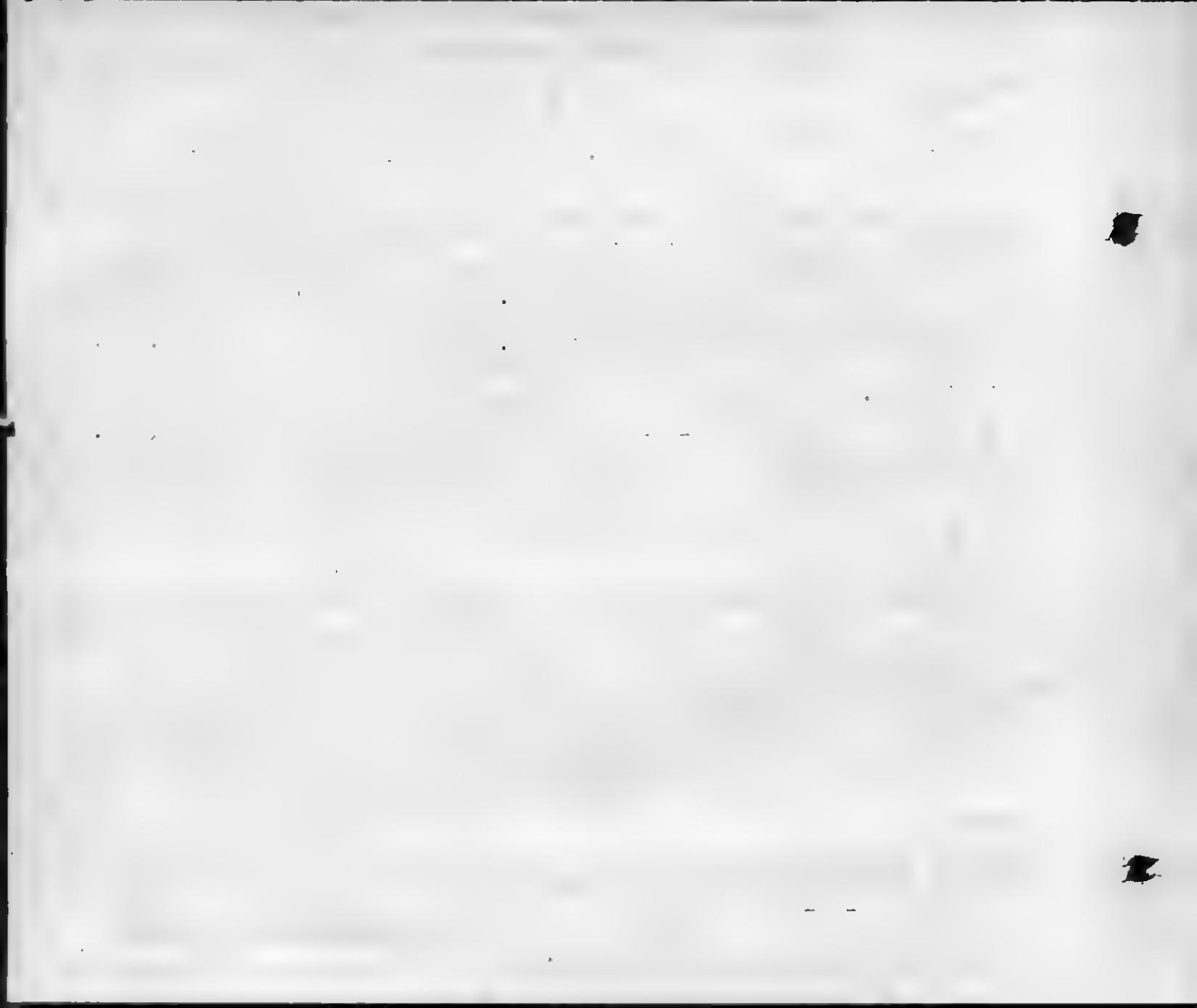
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from _____, 1957, to June 25, 1958, that I last saw the deceased alive on May 29, 1958 , and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church Frederick MD 216-25			
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ACTUAL SIGNATURE Rex R Martin	M.D.	DATE SIGNED 58
PHYSICIAN'S NAME (Type) Rex R Martin		

22a. BURIAL, CREMATION, REMOVAL (Specify) Inurn	22b. DATE THEREOF 6-28-58	22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery	22d. LOCATION (City, town, or county) Lewistown, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager	ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE JUN 27 1958	24b. REGISTRAR'S SIGNATURE John Edwards
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6833

CERTIFICATE OF DEATH

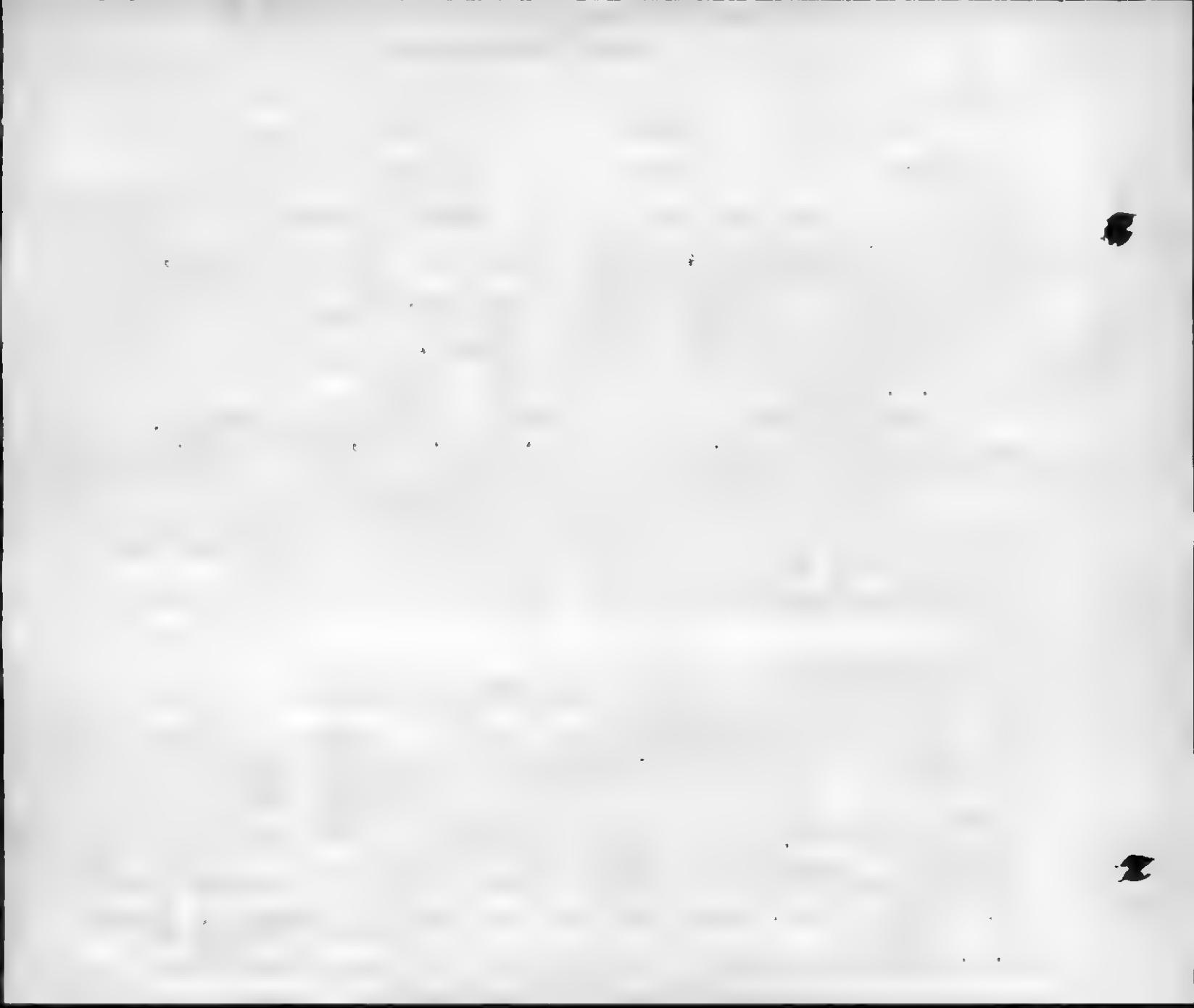
Reg. Dist. No.

06842

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 2 & 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick	Days	Frederick	Frederick
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Frederick Memorial Hospital	Francis Scott Key Hotel		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	MAR	J. BERLIN	RIDDELL
4. DATE OF DEATH	Month	Day	Year
	June	19,	1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	December 25, 1885
9. AGE (In years last birthday) yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country)
72	Domestic	At Home	Penna.
13. CITIZEN OF WHAT COUNTRY?			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
E. H. Berlin		Unknown	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service)		17. SOCIAL SECURITY NO.	
No		?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INFORMANT	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Mrs. John R. Payne, Baltimore 18, Maryland	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH (yr.)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1958</u> , to <u>June 19, 1958</u> , that I last saw the deceased alive on <u>June 19, 1958</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 W 3rd St</u> DATE SIGNED <u>6-19-58</u>			
ACTUAL SIGNATURE <u>Thomas E. Stone</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Thomas E. STONE</u>		Frederick M.d.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>June 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Frederick Memorial Cloister</u>		22d. LOCATION (City, town, or county) <u>Frederick, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Me. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 24 '58</u> 24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

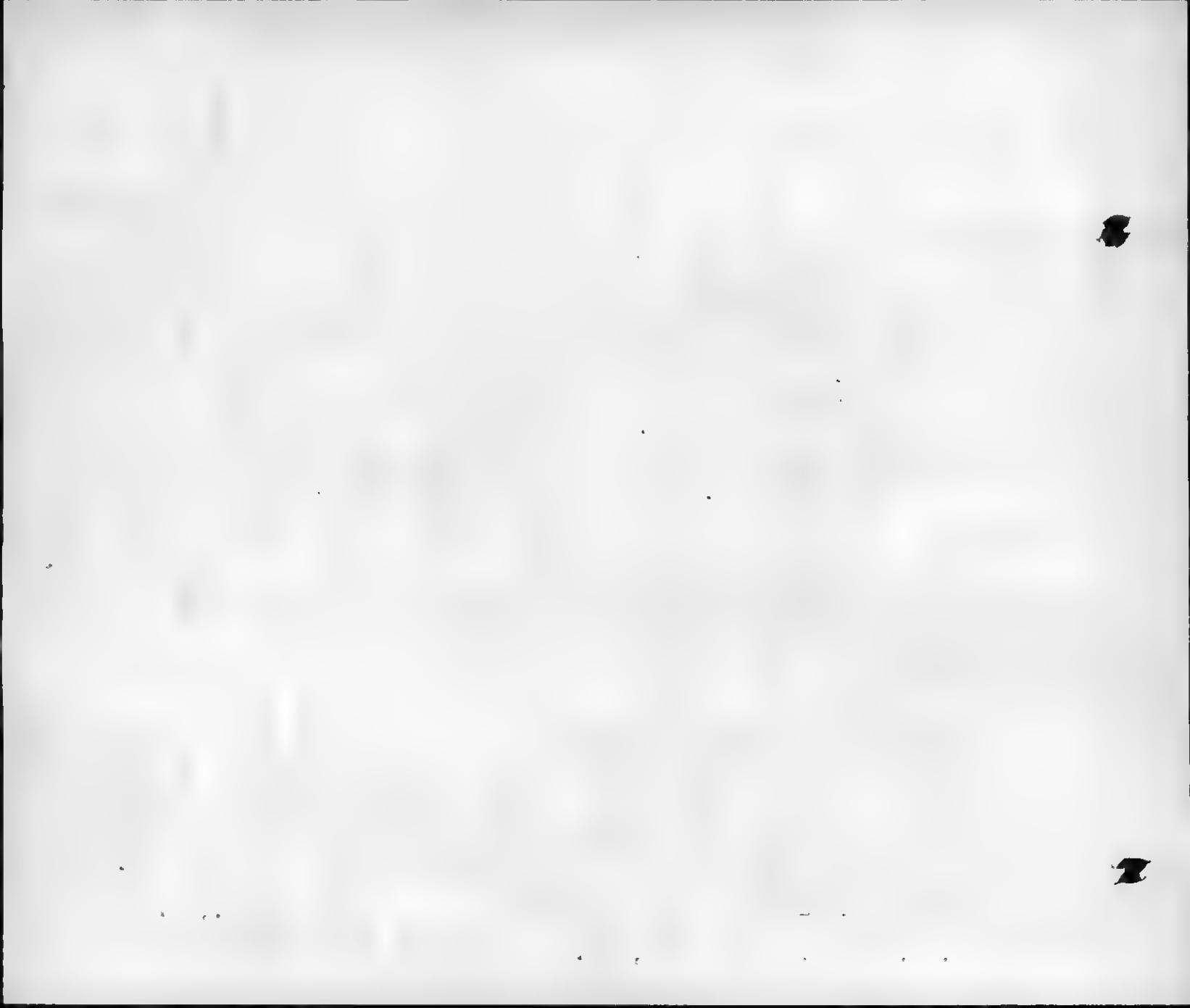
06843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland R.F.D. 4</i>	c. LENGTH OF STAY IN 1b <i>life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland R.F.D. 4</i>	d. STREET ADDRESS <i></i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Augustus School Sr</i>	First <i>William</i>	Middle <i>Augustus</i>	Last <i>School Jr</i>
4. DATE OF DEATH <i>June 7 1958</i>	Month <i>June</i>	Day <i>7</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 03, 1914</i>
9. AGE (In years last birthday) <i>44 yrs.</i>	10. IF UNDER 1YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Frederick Co</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>William Augustus School Sr</i>	14. MOTHER'S MAIDEN NAME <i>Hillie Blanche Cardigan</i>	Address <i>Mr. & Mrs. B. L. Thomas School Maryland R.F.D. 4</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>220-34-7261</i>			
17. INFORMANT <i>Mr. & Mrs. B. L. Thomas School Maryland R.F.D. 4</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation by hanging</i> DUE TO <i>114X</i> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>Minutes 2</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>19</i>	Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. L. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>June 7 1958</i>
EXAMINER'S NAME (Type) <i>B. L. Thomas</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-10-1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Prospect</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. L. Waltz</i>	ADDRESS <i>Winfield, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Welch</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File page 3 and 2 with the registrar prior to burial or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6834 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06844

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, removal, or removal.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Otterbein		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 40		c. LENGTH OF STAY IN TB		d. STREET ADDRESS 1st & 3rd Sts., Rt 4 Ottstown Road.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital									
3. NAME OF DECEASED (Type or print)		First Harold	Middle Burkley	Last Shepherd	4. DATE OF DEATH June 23 1958	Month June	Day 23	Year 1958	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/27/1927	9. AGE (In years last birthday) 30 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Lumber Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James W. Shepherd		14. MOTHER'S MAIDEN NAME Olive Crabtree		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. 823-00-0000		17. INFORMANT Mrs. James W. Harmon - Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest		DUE TO 823-X		INTERVAL BETWEEN ONSET AND DEATH Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Crushed Chest							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASSE CONDITION G VEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Car ran over him at bridge							
20c. TIME OF INJURY Month, Day, Year Hour 5-23-58 6/23 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Route 40		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Route 40, Maryland		20f. (City or town) Frederick Md			
						(County) Maryland			
						(State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE B.C. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/23/58			
EXAMINER'S NAME (Type) B.C. Thomas		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVALS (Specify) Burial		22b. DATE THEREOF 6/26/58		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland Md			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer Cumberland Md.		ADDRESS John J. Hafer Cumberland Md.		24a. REC'D BY REGISTRAR Date Jun 27 '58		24b. REGISTRAR'S SIGNATURE DeLoach			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6835

CERTIFICATE OF DEATH

Reg. Dist. No.

06845

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b over 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 East Fifth Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Daniel		First B.	Middle Smith
4. DATE OF DEATH June 4th 1958	Month June	Day 4th	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 10-1886
9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer	10b. KIND OF BUSINESS OR INDUSTRY Retail	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James H. Smith		14. MOTHER'S MAIDEN NAME Margaret Horne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-32-5117	17. INFORMANT Mrs. Daniel B. Smith-101 E. 5th St.-Frederick-
		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
COPD Colony Thrombosis Cardio vascular disease		30 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 4th 1958 to June 4th 1958 , that I last saw the deceased alive on June 4th 1958 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg.		DATE SIGNED 6/6/58	
ACTUAL SIGNATURE B.O.Thomas		M.D. Professional Bldg.	
PHYSICIAN'S NAME (Type) Dr. B.O.Thomas-Sr.		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick-Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.E.Cline & Son		24a. ADDRESS Frederick-Maryland	24b. REGISTRAR'S SIGNATURE A. L. Schuck
VS A15 (4) 15M 9/55		DATE JUN 9 '58	DATE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06846

6842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) 114 5th Avenue				d. STREET ADDRESS 114 5th Avenue	
3. NAME OF DECEASED (Type or print) Cathy		First Cathy	Middle Mae	Last Spence	4. DATE OF DEATH 6 Month 30 Day Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH 1955	8. AGE (In years less birthday) 2 yrs	9. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lloyd Spence		14. MOTHER'S MAIDEN NAME Thelma Sigler		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Thelma Spence, Brunswick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONVULSION IX					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) BRONCHOPNEUMONIA DUE TO					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-30 , 19 58 , to 6-30 , 19 58 , and that death occurred at Brunswick, Md , from the causes and on the date stated above.		ADDRESS (Street, city or town, State)			
ACTUAL SIGNATURE C. T. BYRON KAO, M.D.		DATE SIGNED 15 S. Maryland Ave.			
PHYSICIAN'S NAME (Type) C. T. BYRON KAO, M.D.					
22a. BURIAL, CREMATION, REMOVAL (if any) BURIAL		22b. DATE THEREOF 7-2-1958		22c. NAME OF CEMETERY OR CREMATORIAL UNION Union	
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Felt		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
				24b. REGISTRAR'S SIGNATURE A. L. Eschuch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6836

CERTIFICATE OF DEATH

06847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Maryland</i>		If institution: Residence before admission b. COUNTY <i>Frederick</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>10 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fred. Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>MYURTIN</i>	Middle <i>MAYNARD</i>	Last <i>SPURRIER</i>	4. DATE OF DEATH <i>June 26 1958</i>	Month <i>June</i>	Day <i>26</i>	Year <i>1958</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct. 8, 1888</i>	9. AGE (In years from birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>69 yrs.</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		14. MOTHER'S MARRIED NAME <i>Juliet Maynard</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-22-9953</i>		17. INFORMANT <i>Mrs. Myurtin m. Spurrier, Walkersville, Md</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>492x</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> <i>Diabetes mellitus mild + rheumatoid arthritis, severe</i>		Acute myocardial failure + pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>				
(b) DUE TO <i>Primary atypical pneumonia</i>		(c)				<i>3 days</i>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus mild + rheumatoid arthritis, severe</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>1 Sep 1948</i> to <i>26 Jun 1958</i> , that I last saw the deceased alive on <i>26 June 1958</i> , and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>Walkersville, Md</i>		
ACTUAL SIGNATURE <i>James E. Stoner Jr.</i>		DATE SIGNED <i>27 June 58</i>								
PHYSICIAN'S NAME (Type) <i>JAMES E. STONER, Jr.</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/29/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>Frederick</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton</i>		ADDRESS <i>Walkersville, Md.</i>		24a. REC'D. BY REGISTRAR <i>JUN 30 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Stoner Jr.</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06848

6837

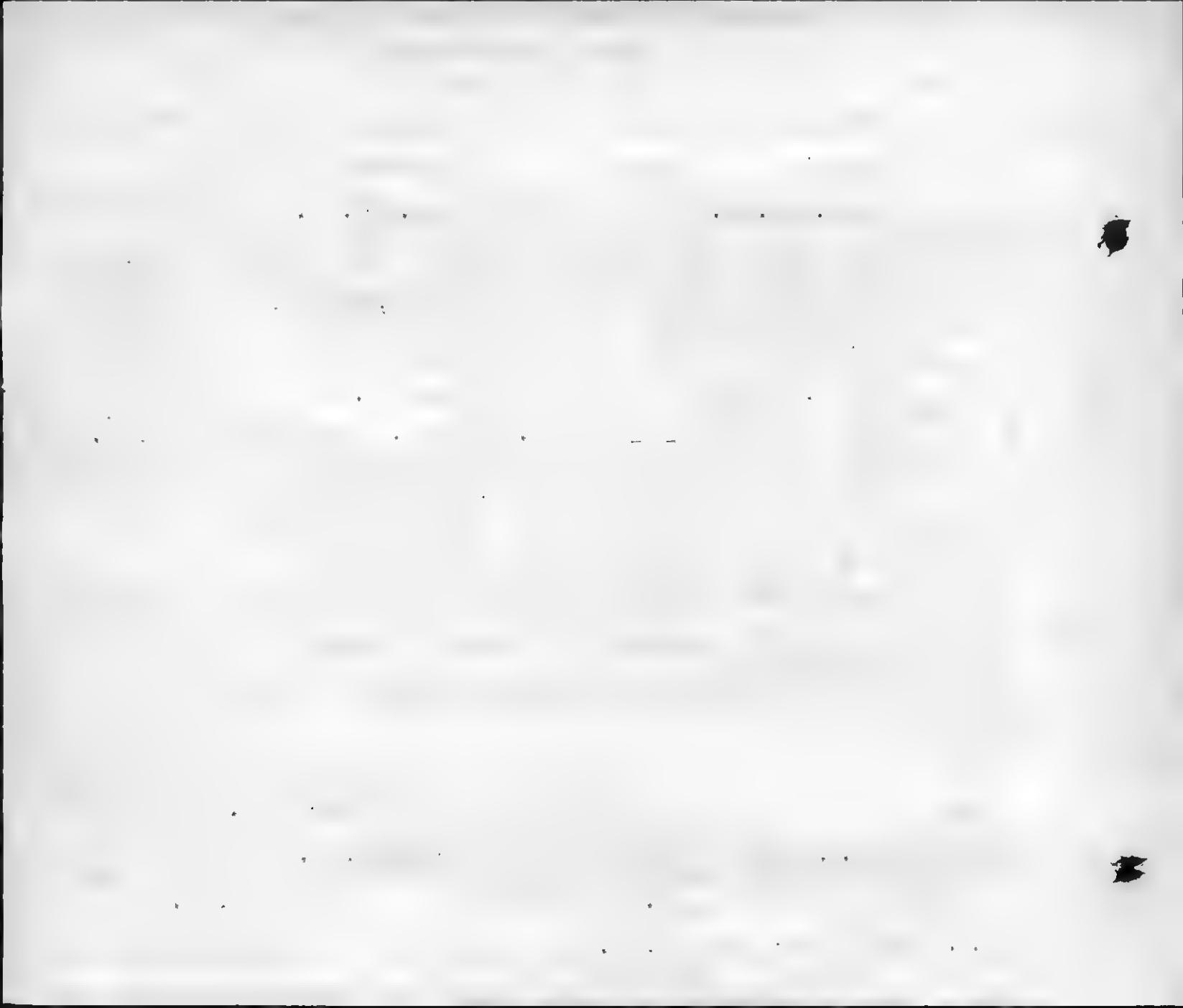
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 E. 11th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LYDIA	Middle CATHERINE	Last STALEY
4. DATE OF DEATH Month June	Month July	Day 29	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus A. Rager		14. MOTHER'S MAIDEN NAME Susan L. Boyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-24-77674	
17. INFORMANT Mrs. Dorothy C. Wenner		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28, 1958 , to June 29, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE B.O. Thomas		ADDRESS (Street, city or town, state) 228 North Market St. DATE SIGNED 7/1/58	
PHYSICIAN'S NAME (Type) Dr. B.O. Thomas		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 2, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son; Frederick, Md.		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
		24b. REGISTRAR'S SIGNATURE Alv. Etchison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be given to the funeral director. Page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6838

CERTIFICATE OF DEATH

06849

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTYTOWN		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle NORMAN	Last STEVENS, SR.	4. DATE OF DEATH Month JUNE	Month 3	Day 19	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/26/1898	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME GEORGE STEVENS		14. MOTHER'S MAIDEN NAME MARY WAGNER		Address MD LIBERTYTOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT GEO. STEVENS JR		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Terminal anemia		INTERVAL BETWEEN ONSET AND DEATH 24 hours
						(b) Essential hypertension and cerebral DUE TO anemia		3 yrs.
						(c) Essential hypertension and cerebral DUE TO anemia		2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Smashed anemia.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from August , 1957, to June 3 , 1958, that I last saw the deceased alive on June 2 , 1958, and that death occurred at 12:45 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE E. A. Dettbarn		PHYSICIAN'S NAME (Type) E. A. DETTBARN		ADDRESS (Street, city or town, state) Melbourne, Md.		DATE SIGNED June 3/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/5/58		22c. NAME OF CEMETERY OR CREMATORIUM FAIRMOUNT CEM.		22d. LOCATION (City, town, or county) LIBERTYTOWN MD		
23. FUNERAL DIRECTOR'S SIGNATURE 100 Hartzlers Sons Libertytown Md		ADDRESS 100 Hartzlers Sons Libertytown Md		24a. REC'D BY REGISTRAR JUN 6 '58		24b. REGISTRAR'S SIGNATURE DeLoach		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6859

CERTIFICATE OF DEATH

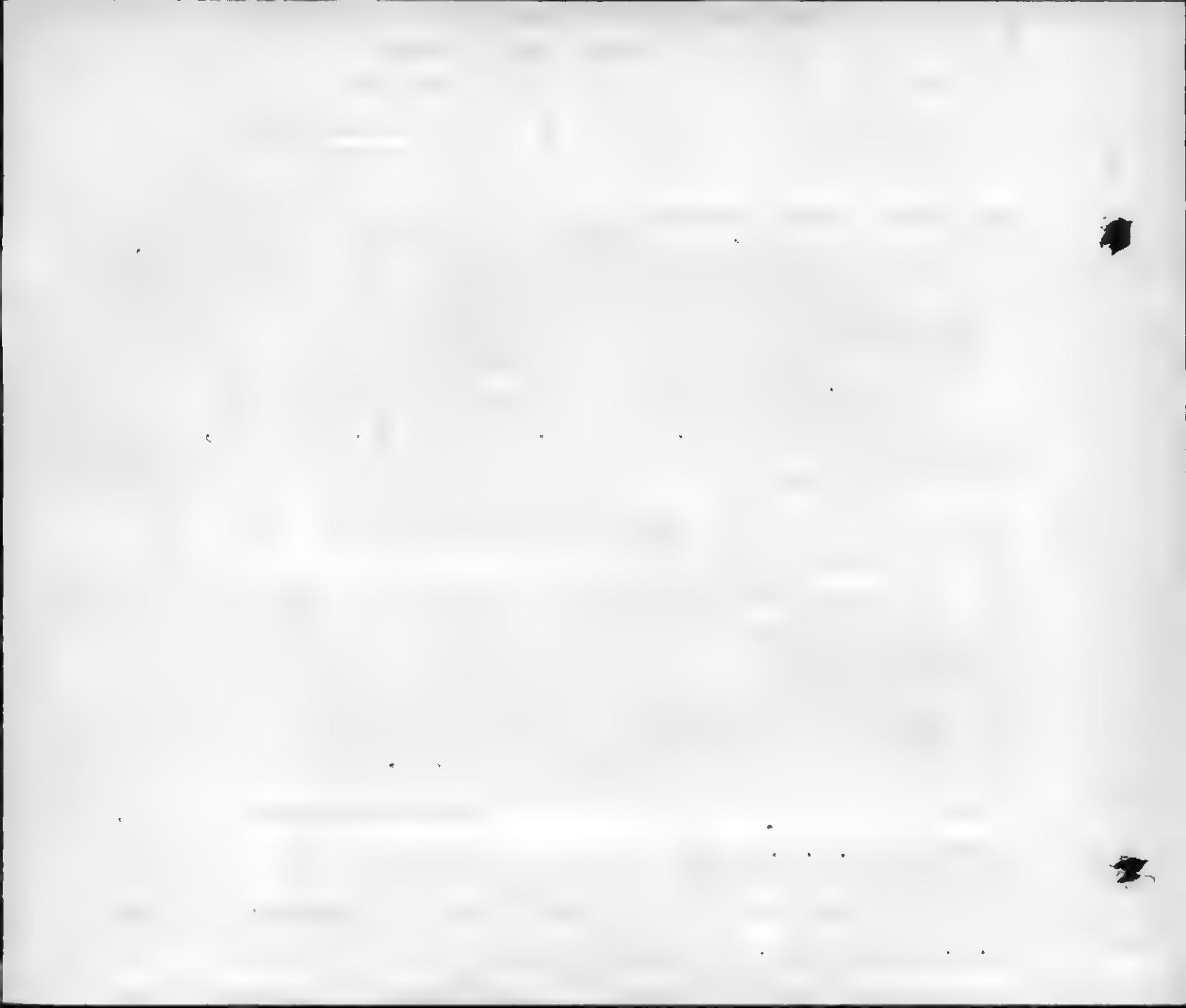
06850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MINNIE	Middle BLANCHE	Last STRAILMAN	4. DATE OF DEATH June 20, 1958	Month June	Day 20	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1894		9. AGE (In years from birthday) 63 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John J. Ponton				14. MOTHER'S MAIDEN NAME Sallie Jane Lowe				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mr. Leo Strailman, Buckeystown, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick	(County) Frederick	(State) Maryland
21. I certify that I attended the deceased from May 16, 1953 to June 20, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 6/21/1958								
ACTUAL SIGNATURE B. O. Thomas		M.D.						
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas		Frederick, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JUN 24 '58		24b. REGISTRAR'S SIGNATURE Alfred Beach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06851

6860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont-Rural RD#1		c. LENGTH OF STAY IN lb Since 8/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3		d. STREET ADDRESS Bloomfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Putman Road, Near Lewistown				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELLIOTTE	Middle LYCURGUS	Last WACHTER	4. DATE OF DEATH	Month June	Day 4,	Year 1958
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 14 Jan 1872	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months 86	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley A. Wachter				14. MOTHER'S MAIDEN NAME Susanna V. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT William L. Wachter (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Anterior-clerotic heart disease (c) INTERVAL BETWEEN ONSET AND DEATH Minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James B. Thomas M.D. 228 N. Market St. 6-6-58							
PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-58		22c. NAME OF CEMETERY OR CREMATORIUM Zion Cemetery		22d. LOCATION (City, town, or county) Charlesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
						24b. REGISTRAR'S SIGNATURE Albert E. Etchison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6839

CERTIFICATE OF DEATH

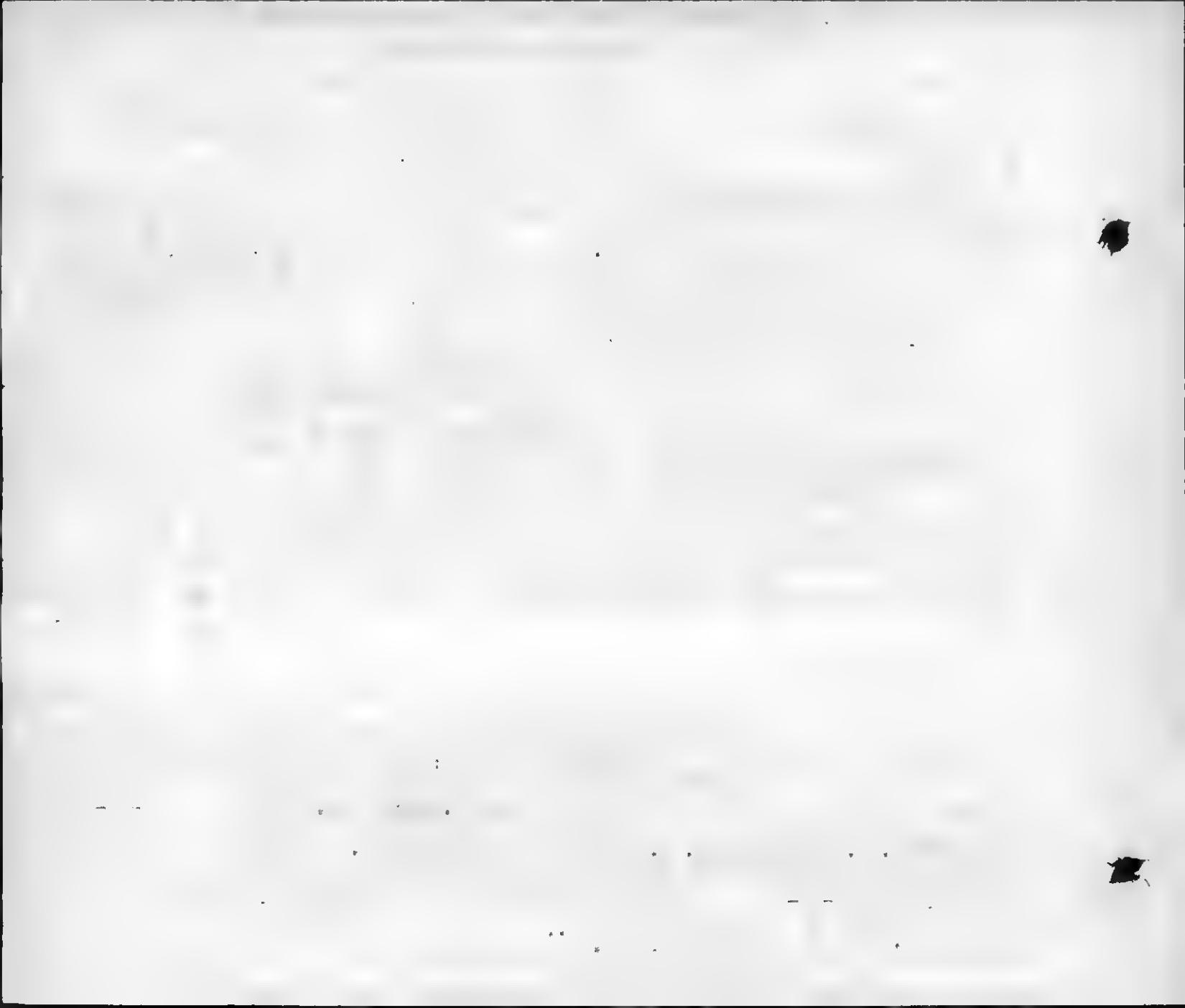
06852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b. 1 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 633 Lee Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JULIA	Middle A.	Last WAHL	4. DATE OF DEATH	Month June 26,	Day 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Apr 1887	9. AGE (In years last birthday yrs.) 71	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Godwin		14. MOTHER'S MAIDEN NAME Annie (Last name unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Raymond Wahl (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 332X		DUE TO Bronchitis pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		(b) DUE TO Cerebral thrombosis		6 days			
		(c) DUE TO Autonomic seborrheic		many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ June 20, 1958 to _____ June 26, 1958 , that I last saw the deceased alive on _____ June 26, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 6-27-58	
ACTUAL SIGNATURE L. R. Schoolman		M.D.		228 N. Market St.			
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.		Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-30-58		22c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery		22d. LOCATION (City, town, or county) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Albert J. McCrery		24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Albert J. McCrery			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

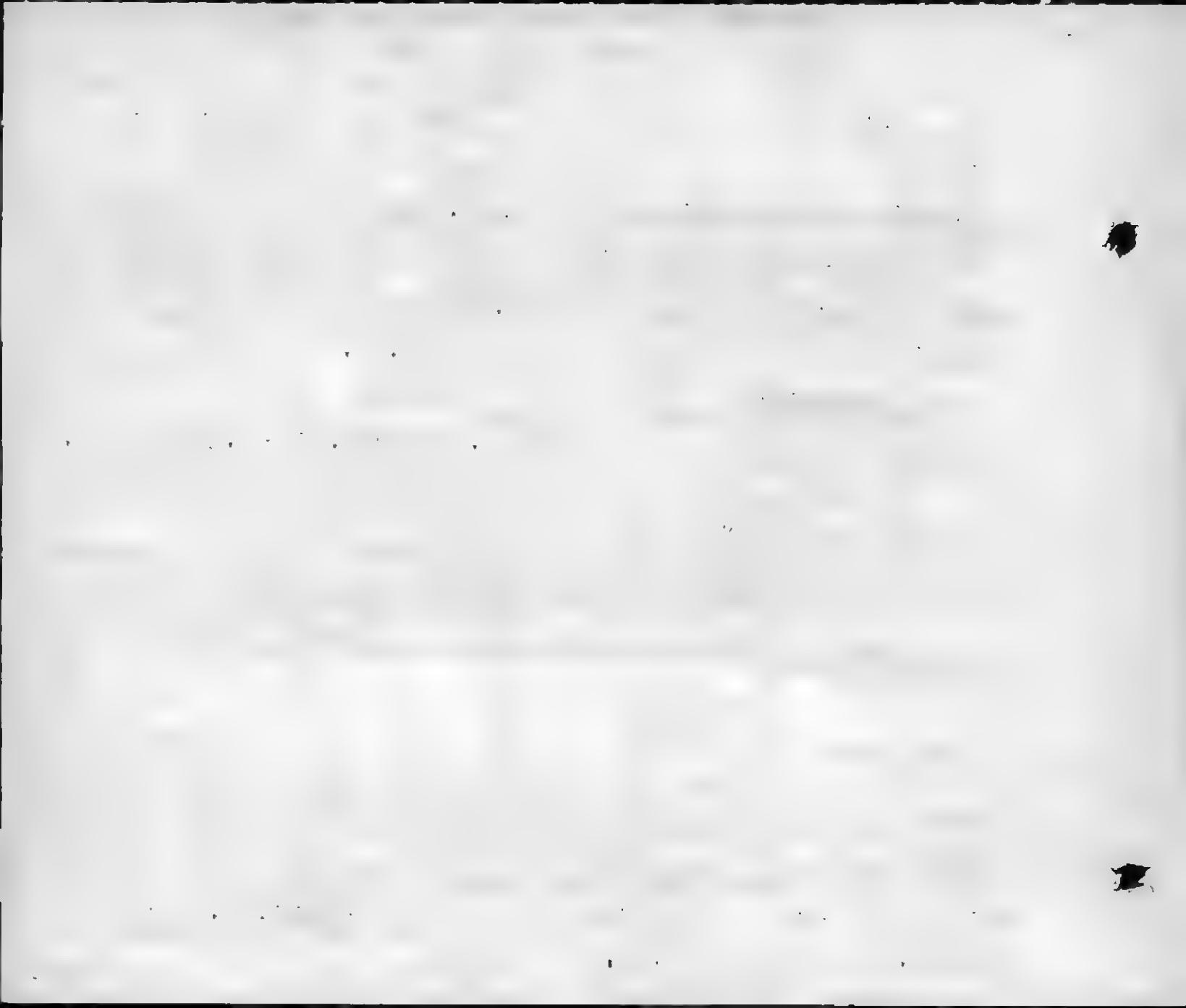
6840

CERTIFICATE OF DEATH

06853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 23 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Ella Joanne Clarke Whiting		d. STREET ADDRESS 103 S. Bentz	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		First Colored	Middle WIDOWED
6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 16-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Howard Co. Md.
13. FATHER'S NAME Hugh Henry Clarke		14. MOTHER'S MAIDEN NAME Eliza Gaither	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT James M. Gaither-Mt. Airy-Rt. 3 Carroll Co. Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Address <i>Arterosclerotic + diabetis gangrene of foot 1 year</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
DUE TO (c)		<i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>57</u> to <u>6-3-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-3-</u> , 19 <u>58</u> , and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Rex R. Martin</i> PHYSICIAN'S NAME (Type) <i>Rex R. Mart. Jr.</i>		ADDRESS (Street, city or town, state) <i>35 E Church Frederick Md</i> DATE SIGNED <i>6-6-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-6-58	22c. NAME OF CEMETERY OR CREMATORIUM Fairview
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks 111 Frederick, Md.		24a. REGISTRY REGISTRAR ADDRESS <i>111 W. Church St. Frederick, Md.</i> DATE	24b. REGISTRAR'S SIGNATURE <i>Abdullah</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6861

CERTIFICATE OF DEATH

06854
Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 39 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		d. STREET ADDRESS St. Mary's Terrace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Terence	Middle P.	Last Woods	4. DATE OF DEATH July 30, 1879	Month June	Day 23	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 30, 1879	9. AGE (in years from birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY No specific industry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick Woods			14. MOTHER'S MAIDEN NAME Mary Ann Keating						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records of Victor Cullen State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Cardio-Respiratory Failure									
DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under- lying cause last. (b) Far Advanced Pulmonary Tuberculosis 39 days DUE TO (c)									
(Onset about 1 yr. ago)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg Cemetery		20f. (City or town) Frostburg		(County) Maryland	(State) MD
21. I certify that I attended the deceased from 5/15/1958 to 6/23/1958 , that I last saw the deceased alive on 6/22 1958 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) M.D. Victor Cullen State Hospital									
DATE SIGNED 6/23/58									
ACTUAL SIGNATURE <i>Michael G. Zavis</i>									
PHYSICIAN'S NAME (Type) Michael G. Zavis, M.D.		Cullen, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-58		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Cemetery		22d. LOCATION (City, town, or county) Frostburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. L. Greger & Son</i>		ADDRESS Theurmont, Md.		24a. REC'D BY REGISTRAR JUN 24 1958		24b. REGISTRAR'S SIGNATURE <i>Rebecca</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6841 CERTIFICATE OF DEATH

06855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USU. RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Brunswick	
3. NAME OF DECEASED (Type or print) Mary		First B.	Middle Wyn Koop
4. DATE OF DEATH June 25 1958		Last 71	Month Day Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-23-1886		9. AGE (in years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME T.T. Thomas		14. MOTHER'S MAIDEN NAME Margaret Mathews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 443X	
17. INFORMANT Mrs. Cleo Cannon, Frederick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hypertension Cardiovascular disease		(b) DUE TO 3 years	
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/20 , 1958, to 6/25 , 1958, that I last saw the deceased alive on 6/25 , 1958, and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St	
PHYSICIAN'S NAME (Type) Henry V. Chase		DATE SIGNED 6/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE HEREOF 6-28-1958	
22c. NAME OF CEMETERY OR CREMATORIUM St. Marks		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Gub		24a. REC'D BY REGISTRAR DATE JUL 1 '58	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Rees	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.
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Digitized by srujanika@gmail.com

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10. *Leucania* *luteola* (Hufnagel) (Fig. 10).
Lepidoptera: Noctuidae.